2008

Early marriage and sexual and reproductive health risks: Experiences of young women and men in Andhra Pradesh and Madhya Pradesh, India

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This report is the result of an exploratory study of married young women and men in Andhra Pradesh and Madhya Pradesh with regard to their situation and vulnerability to HIV and other adverse sexual and reproductive health outcomes. The study was conducted by the Population Council, as part of a larger project entitled *Towards Messages that Matter: Understanding and Addressing the HIV and Sexual and Reproductive Health Risks of Married Young People in India,* undertaken by the Council in partnership with the Family Planning Association of India, with support from the Department for International Development, UK.

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Suggested citation: Santhya, K.G., S.J. Jejeebhoy and S. Ghosh. 2008. *Early marriage and sexual and reproductive health risks: Experiences of young women and men in Andhra Pradesh and Madhya Pradesh, India.* New Delhi: Population Council.

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Contents

List of tables and figures

Acknowledgements

This study has benefited immeasurably from the input of many. The study was supported by a grant from the Department for International Development, UK, to the Population Council, and we are grateful for their support over the course of the project.

We are grateful to the young women and men of Guntur district, Andhra Pradesh and Dhar and Guna districts, Madhya Pradesh who generously gave us their time and shared their views and experiences. We would like to thank the various government departments in Andhra Pradesh and Madhya Pradesh for granting permission to conduct this study. We appreciate the efforts of the investigators who painstakingly collected the data, and the invaluable insights provided by the participants of the data interpretation workshops, including the District Collector and local government representatives. A special thanks goes to colleagues at the Family Planning Association of India, Bhopal and Hyderabad for providing support during data collection, and the staff of SEEDS, Guntur for their support during the data interpretation workshop.

We would like to thank Saroj Pachauri for her support throughout the study. Rajib Acharya provided valuable guidance in designing the study. John Cleland and Venkatesh Srinivasan reviewed an earlier draft of the report and provided thoughtful comments. We are grateful to Deepika Ganju for her editorial contribution and careful attention to detail. We would also like to thank Komal Saxena and M.A. Jose for their valuable assistance during the project.

Executive summary

In India, recent programmatic initiatives in the field of adolescent and youth sexual and reproductive health have begun to recognise the heterogeneity of young people. Although sound evidence is limited on the distinct vulnerabilities of different sub-groups of young people, emerging research shows that married young women and men constitute groups at distinct risk of HIV and other adverse sexual and reproductive health outcomes. Moreover, marriage is not necessarily a protective factor for a sizeable proportion of married youth, particularly married young women. In this context, there is a critical need to better understand the unique needs and vulnerabilities of both married young women and men, and to design programmes that take account of their special circumstances. To begin to fill this gap, the Population Council undertook a large-scale study of married young women and men in two rural settings to assess their situation and vulnerability to HIV and other adverse sexual and reproductive health outcomes.

A cross-sectional study, comprising a pre-survey qualitative phase and a survey, was conducted in rural sites in Guntur district, Andhra Pradesh, characterised by low median age at marriage and first birth, and high prevalence of sexually transmitted infection (STI) and HIV, and in Dhar and Guna districts of Madhya Pradesh, characterised by low median age at marriage and first birth, and low levels of STI and HIV. Study participants included married young women aged 15–24 and married young men aged 15–29. A total of 3,087 young women and 2,622 young men were interviewed using a structured questionnaire.

The study clearly underscores the vulnerability of married youth to STI/HIV as a result of risky sexual experiences before, within and after marriage. It also highlights the vulnerability of married young women to early and unplanned pregnancies and pregnancy-related complications. Findings suggest wide gender differences and, to some extent, setting-specific differences in the risk profile of married young people.

Findings on sexual experiences indicate that irrespective of the setting, premarital and extra-marital sexual relationships, often characterised by multiple partnerships, were common among young men. A small minority of young women also reported such experiences. Irrespective of whether sexual experiences took place before, within or outside marriage, the use of condoms was limited. Moreover, sexual experiences were coercive for substantial proportions of young women, irrespective of whether sex took place before, within or outside marriage.

Vulnerability to STI/HIV was clearly exacerbated by inadequate care seeking for symptoms of genital tract infection. For example, while only a small proportion of young people reported having experienced symptoms of genital tract infection, no more than one in four young women or men in either setting had sought treatment as soon as symptoms were noticed. Likewise, few respondents took action to prevent the transmission of infection to their spouses either by informing them of the infection or asking their spouses to go for a check-up. Similarly, few respondents reported that they either abstained from sex or used a condom while having sex when they had experienced symptoms of genital tract infection.

Findings also confirm the vulnerability of married young women to early and unplanned pregnancies. The practice of contraception was far from universal in both settings. Even among the small proportion who desired to delay the first pregnancy, few succeeded in using a non-terminal contraceptive method. Indeed, the majority of those who practised any form of contraception reported female sterilisation as the first method used. Not surprisingly, sizeable proportions of women became mothers at a young age; two in five young women in Guntur and one in three in Dhar and Guna reported a first birth by age 18. Findings also highlight substantial unplanned pregnancy in both settings, particularly in Dhar and Guna.

Young women were also vulnerable to poor pregnancy-related experiences. Comprehensive antenatal care was reported by about half of all respondents in Guntur compared to under one-fifth of those from Dhar and Guna. Skilled attendance at delivery was not universal, with about one in seven women in Guntur and about half in Dhar and Guna reporting delivery by an unskilled person. Similarly, seeking treatment for pregnancy-related complications was limited. While the situation with regard to the practice of antenatal check-ups, institutional delivery and seeking treatment for pregnancy-related complications was far better in Guntur than in Dhar and Guna, the practice of accessing postpartum services was found to be limited in both settings.

The study also explored several background factors that might influence married young people's ability to adopt protective behaviours and practices to reduce their risk of acquiring or transmitting STI/HIV, and at the same time, make pregnancy safer and address their unmet need for contraception. Findings underscore that awareness of most sexual and reproductive health matters was limited. For example, no more than 43 percent of young women or men in either setting were aware that a woman can get pregnant the first time she has sexual intercourse. Similarly, while awareness of the importance of regular antenatal check-ups was widespread, awareness of the need for postpartum check-ups was not as widely recognised. Attitudes towards protective actions were mixed. By and large, young people—irrespective of gender and setting—appeared to favour premarital HIV testing. In contrast, attitudes towards condom use reflected young people's association of condoms with unfaithfulness, sex work and so on; these attitudes tended to be more unfavourable in Guntur than in Dhar and Guna. Likewise, perceptions of personal risk of acquiring STI/HIV were low, even among those who reported such risky behaviours and situations as coercive sex, non-use of condoms or multiple partner relations.

Unequal gender norms and power imbalances appeared to characterise the sexual relationships of the majority of respondents in both settings both within and outside marriage, underscoring young women's inability to negotiate safe sexual practices with their husbands as well as their pre- and extra-marital partners. Findings suggest in general that married young women played a limited role in household decision-making, had little freedom of movement in their marital villages and had limited access to resources. Additionally, they were subjected to both emotional and physical violence and controlling behaviours by their husbands. While a large proportion of couples did indeed communicate on general and non-sensitive topics, many fewer reported that they discussed sexual and reproductive health matters; indeed, limited couple communication on these sensitive topics further undermined married young people's ability to adopt protective actions in these settings.

Large proportions of respondents reported access to family or social support. However, while the majority had access to some form of family or peer support, a significant minority noted that they would not discuss sensitive sexual matters with anyone.

Access to information on sexual and reproductive health was by and large limited, and varied by topic. For example, young people were least likely to have been exposed to messages related to STIs other than HIV in the recent past. Findings also highlight that young people's interaction with a health care provider on sexual and reproductive health topics in the recent past was limited. Few young women and men in both settings reported that a health worker had discussed with them the option of practising contraception to delay the first pregnancy or using condoms for dual protection. However, considerably larger proportions noted that a health care provider had discussed topics related to maternal health including care during pregnancy and danger signs during pregnancy, childbirth and the postpartum period at the time of their first pregnancy.

Study findings clearly suggest that married youth are a distinct group that has experienced a wide range of risky behaviours; moreover, they face a number of obstacles that limit their ability to exercise safe choices in the area of sexual and reproductive health. Findings reiterate the need for programmatic attention to address the special needs and vulnerability of married young women and men. There is a need to provide detailed information on sexual and reproductive health matters to married young people, as well as those about-to-be-married and the unmarried; such efforts should be tailored not only to raise awareness but also to enable young people to correctly assess their own and their partner's risk, and to adopt appropriate protective actions.

Current efforts at condom promotion need to reposition the condom so that it is recognised as a safe and effective method for use within marriage—and especially for young people who have a need for spacing births—and to dispel the stigma currently associated with its use among married young women and men. In view of the fact that most married young women and men who were practising contraception had adopted female sterilisation, it is important to convey the benefits of condom use even among the sterilised who are unlikely to recognise the need for dual protection.

Findings regarding the pervasiveness of sexual coercion in premarital, marital and extra-marital sex clearly indicate that sexual and reproductive health programmes must address the issue of coercion within sexual relationships. Whether it is their goal to assist women in protecting themselves from HIV infection or to provide women with contraception, these programmes must take into consideration the fact that a significant proportion of their clients engage in sexual relations against their will, and that messages that advocate faithfulness and condom use are irrelevant where sexual relations are non-consensual.

Programmatic efforts are also needed to support young people to postpone the first pregnancy, to build awareness of the adverse effects of early pregnancy and to make it acceptable for young couples, in particular newly-weds, to adopt contraception prior to the first birth. At the same time, there is a need to change community and family attitudes to favour postponement of pregnancy and not link a young woman's security within the marital family with her childbearing ability. It is clear, moreover, that health care providers do not reach married young women and men—particularly those who have not yet experienced pregnancy—with information regarding contraception and supplies, thereby contributing to the significant proportions reporting

unplanned pregnancies. Such findings clearly indicate the need to reorient programmes to focus on married young people's special need for spacing pregnancies, particularly in Dhar and Guna.

Findings underscore that access to maternal health services was far from universal, even at the time of the first—and often the most risky—pregnancy. Few women, particularly in Dhar and Guna, had accessed care during the antenatal, delivery and postpartum periods. These findings highlight that reproductive and child health programmes need to lay emphasis on increasing the demand for such services as well as improving the availability of such services. Given that postpartum check-ups were rarely accessed, despite the fact that significant proportions were aware of the importance of such check-ups, health care providers need to make a special effort to reach young mothers in the immediate postpartum period.

Findings reaffirm the underlying role of gender double standards and power imbalances that limit the exercise of informed choice among young couples. Programmes need to promote actions that empower young people, particularly young women, and at the same time, promote messages that build egalitarian relations between women and men.

Although findings clearly indicate that married young people were at risk of adverse sexual and reproductive health outcomes, efforts by health care providers to reach them were limited. Clearly, there is a need to sensitise health care providers to the special needs and vulnerability of married young people and orient them to the need for developing appropriate strategies to reach diverse groups of young people, including married young women and men.

In conclusion, findings of this study show that married youth are a particularly vulnerable group that is in need of multi-pronged programmatic attention that addresses not only their own risk behaviours, but also the likely factors contributing to these risks. These programme efforts need to focus not only on married young people themselves but also their families, the community and health care providers who also play a significant role in enabling married youth to make informed, safe and wanted sexual and reproductive health choices.

CHAPTER 1

Introduction

In India, recent programmatic initiatives in the field of adolescent and youth sexual and reproductive health have begun to recognise the heterogeneity of young people. Indeed, the Reproductive and Child Health (RCH) Programme II notes that "friendly services are to be made available for all adolescents, married and unmarried, girls and boys" (MOHFW, 2006). The National Rural Health Mission (2005–2012), that has integrated several vertical health programmes including the RCH Programme, has incorporated adolescent health services at sub-centre and primary health centre level, and in schools among the service guarantees for health care under the Mission (MOHFW, 2005). However, sound evidence is limited on the distinct vulnerabilities of different sub-groups of young people and the factors underlying these vulnerabilities, which could facilitate the design of group-appropriate interventions. Nonetheless, emerging research suggests that within the sub-population of young people, married young men and women constitute groups at distinct risk of HIV and other poor sexual and reproductive health outcomes; moreover, marriage is not necessarily a protective factor for a sizeable proportion of married youth, particularly married young women (Clark, Bruce and Dude, 2006; Santhya and Jejeebhoy, 2003; 2007a). In this scenario, there is a critical need to better understand the unique needs and vulnerabilities of both married young women and men, and to design programmes that take into account their special circumstances.

This report presents findings from a large-scale survey focusing on the situation and vulnerability of married young women and men to HIV and other adverse sexual and reproductive health outcomes. The study was conducted in rural settings in the states of Andhra Pradesh and Madhya Pradesh.

Background

A growing body of research suggests that while in different ways, both married young women and men are vulnerable to adverse sexual and reproductive health outcomes; indeed, these outcomes may result from risky practices adopted prior to and within marriage. Evidence also suggests that the pathways to risk are different for females and males.

First, marriage continues to take place in adolescence for significant proportions of young women in India. While age at marriage for women has undergone a secular increase, the reality is that as recently as 2005–2006 more than two-fifths of all women aged 20–24 were married by 18 years (IIPS and Macro International, 2007a). Marriage at a young age—often in the absence of physical and emotional maturity—undermines the ability of young women to make informed decisions about their lives. Early marriage is far less prevalent among young men; however, over one-fourth (29%) of young men aged 25–29 were married by age 21 (IIPS and Macro International, 2007a).

Second, young women and men enter marriage with vastly different premarital sexual experiences and risk profiles. Sexual activity among young women takes place overwhelmingly within the context of marriage; in contrast, marriage does not necessarily mark the initiation of sex for boys. Available evidence

suggests that fewer than 10 percent of unmarried girls in India are sexually experienced while some 15–30 percent of boys are reported to have had premarital sex (Jejeebhoy and Sebastian, 2004). Evidence from a community-based study in Pune district, Maharashtra, shows, for example, that 16–18 percent of unmarried young men and 1–2 percent of unmarried young women in rural and urban settings reported premarital sex. Corresponding figures for premarital sex among the currently married were 15 percent among rural men and 22 percent among men from an urban slum setting, and 2–4 percent among young women, irrespective of residence. Moreover, of the sexually experienced, between one-fifth and one-quarter of young men reported relations with more than one partner, including casual partners, sex workers and older married women, compared to one in 20 young women (Alexander et al., 2006). These findings suggest the likelihood that some sexually experienced young men may already be HIV-positive at the time of marriage, and that others who engage in risky extra-marital relations may become positive within marriage; indeed, these findings are corroborated by evidence from a few available studies (Brahme et al., 2005; Singh and Kumari, 2000). The disparity in the extent to which young men and women engage in risky sexual behaviours before marriage, together with the fact that girls who marry early are socially and economically disadvantaged, suggests that married young women are at special risk of acquiring HIV; a finding reflected in a number of studies (APSACS, 2002; Gangakhedkar et al., 1997; Kumar et al., 2006; Mehta et al., 2006; Newmann et al., 2000).

Third, in settings characterised by early marriage and early childbearing, girls face enormous pressure to initiate childbearing as soon as possible after marriage. They are thus far more likely to experience regular sexual relations, less likely to use condoms and less likely to refuse sex than are unmarried sexually active adolescents or adult women, which places them at higher risk than unmarried sexually active women of acquiring sexually transmitted infections (STIs); young married women are also at a higher risk than married adult women of obstetric complications associated with early childbearing (National Research Council and Institute of Medicine, 2005). Evidence from community- and facility-based studies also shows that adolescents are significantly more likely to experience maternal death than are older women (Bhatia, 1988; Krishna, 1995). Peri-natal and neonatal mortality are also significantly higher among adolescent mothers than among those in their 20s and 30s (IIPS and Macro International, 2007a). However, despite the fact that many females experience their first pregnancy in adolescence and consequently face higher risk of maternal morbidity and mortality than older mothers, there is little evidence that care seeking is more pronounced among them than older women; for example, data from National Family Health Survey (NFHS)-2 show that two-thirds in each group received antenatal care and 42–43 percent delivered with a trained attendant (Santhya and Jejeebhoy, 2003).

While the evidence presented above indicates married young women's and men's vulnerability to HIV and other adverse sexual and reproductive health outcomes, the factors underlying exposure to risk remain, unfortunately, poorly understood. Extrapolating evidence from small and unrepresentative studies conducted thus far among married youth (Jejeebhoy and Sebastian, 2004), three sets of factors have been identified that underlie these risks: lack of in-depth awareness of protective behaviours and misperceptions of personal risk; lack

of access, in practice, to services and sensitive providers; and in egalitarian gender norms and power imbalances.

Lack of in-depth awareness of protective behaviours has often been cited as a significant impediment to the adoption of safe sex practices (Jejeebhoy and Sebastian, 2004; Santhya and Jejeebhoy, 2007a). Although programmes have been initiated that focus on enhancing awareness among young people of issues related to sexual and reproductive health, married adolescent girls and young women—and to a lesser extent married young men—are less likely to be reached by these initiatives than are the unmarried. For example, most HIV/AIDS prevention programmes in India focus on young unmarried students in schools and colleges through School AIDS Education Programmes and the University Talk AIDS Programme. However, given that the vast majority of India's adolescent girls do not attend secondary school, much less higher education, the school and University programmes have inherently limited reach. The Village Talk AIDS Programme, which works through networks of youth organisations, including sports clubs, the National Student Service and Nehru Yuvak Kendras, is, in theory, designed for out-of-school unmarried and married youth; however, as most of these organisations cater largely to young men, this programme is unlikely to reach married girls and young women (Santhya and Jejeebhoy, 2007b).

Related to lack of awareness are young people's perceptions of self-risk and vulnerability to reproductive health risks, including HIV. Evidence suggests that even youth who are aware of the risks associated with unprotected sex do not always perceive themselves to be at risk, even when they adopt unsafe sex practices (Macintyre et al., 2003; Prata et al., 2006). Moreover, in assessing self-risk, married young women may not take into consideration (or even be aware of) their husband's premarital and extra-marital sexual relationships. Young husbands themselves may discount the risks posed by their premarital sexual relationships, especially if they have experienced no obvious symptoms. The widespread perception that one can tell from the way a person looks whether s/he is infected with HIV may, likewise, contribute to the belief among young men that if they engage in sex with a healthy looking person, they are not at risk of infection.

A second set of obstacles relates to lack of access to appropriate services, supplies and providers. Reproductive and child health programmes do not take cognisance of the needs of married young women and constraints they face in accessing services. For example, there is a tendency to overlook the fact that newly married women may not have the necessary mobility, decision-making ability or access to resources in their marital homes to seek information, counselling or care on their own, and therefore, require more concerted provider contacts within the home setting than older women (IIPS and ORC Macro, 2000). The outreach of health and family welfare workers under the RCH Programme also tends to neglect married adolescent girls and young women until they have proved their fertility. Likewise, the RCH Programme, viewed as a largely female-centred programme, completely excludes men, married or unmarried, adult or young, from its purview; as a result, married young men's ability to access providers for counselling, supplies or services with regard to safe sex, treatment of infections as well as pregnancy-related care for their wives is limited.

The third and perhaps the most intractable set of factors in a patriarchal, age- and gender-stratified

setting such as India relates to gender norms and power imbalances and the sexual and reproductive risks they pose to the lives of married young women and men. As is well-known, for many young couples, marriage occurs essentially with a stranger, with whom the young person has had little or no prior acquaintance. Village exogamy also means that often married young women are deprived of natal family support in their marital homes. Newly married young women are, moreover, particularly vulnerable as they are unable to exercise choice in their husbands' homes; of note are their limited decision-making ability in all matters including sexual and reproductive health, their lack of access to or control over economic resources, their limited intimacy with their husbands and lack of social support more generally, and their restricted mobility. Norms regarding "proper" feminine behaviour foster submissiveness among wives. Gender-based violence, both physical and sexual, within marriage is, likewise, a key factor influencing poor sexual and reproductive health outcomes, including STIs, and poor maternal and child health outcomes, such as foetal wastage and infant death (Jejeebhoy, 1998; Martin et al., 1999).

A different set of gender-related factors underlie married young men's vulnerability to adverse health outcomes. While young men may not be subjected to the same stringent behavioural norms as those imposed on young women, emerging evidence indicates that young age and the social construction of masculinity may undermine married young men's role in sexual and reproductive health decision-making, limit their involvement in the care and support of their wives in these matters and constrain their ability to adopt protective behaviours. For example, studies that explored the role of young husbands in decisions related to the use of contraception and timing of first pregnancy noted that such decisions were beyond the control of a substantial proportion of young men. Indeed, even where young couples would have liked to have delayed pregnancy, the decision to practise contraception was often overruled by senior family members (Barua and Kurz, 2001; Santhya et al., 2003). Findings from the above-referred studies also suggest that prevailing norms of masculinity may constrain married young men from seeking information on safe motherhood practices as these matters are believed to be a woman's domain, and inhibit them from playing a supportive role during their wives' pregnancy or in the postpartum period even if they wanted to do so. Moreover, married and unmarried young men are affected by social norms that condone sex at an early age and a sense of entitlement among young men to engage in sex within and outside of marriage, often under risky conditions, which puts them and their partners at risk of acquiring/transmitting STIs/HIV (Jejeebhoy and Sebastian, 2004). Evidence also suggests clear linkages between inegalitarian gender attitudes and norms of masculinity on the one hand, and high-risk behaviours among men, including unprotected sex and gender-based violence, on the other (Verma et al., 2006). Studies elsewhere have shown that expectations that men are self-reliant, sexually experienced and more knowledgeable than women inhibit men from seeking treatment, information about sex and protection against infections, and from discussing sexual health problems (Blanc, 2001).

In short, the vulnerabilities of married young women and men are immense and distinct and need urgent action. There is a clear need for specially targeted—but differently focused—programmatic efforts that aim to reduce the risks these groups face, specifically of acquiring and transmitting HIV, as well as experiencing poor reproductive health outcomes in terms of pregnancy-related complications, unmet

need for contraception and the inability to exercise choice more generally. Unfortunately, there is a dearth of research in India thus far that can inform programmes or identify implementation strategies to enable married young women and men to overcome these significant obstacles.

Study objectives

The study aimed to better understand married young women's and men's sexual and reproductive health situation and vulnerability, and the factors underlying their vulnerability. Specifically, the objectives of the study were to:

- Assess the extent to which married young women and men engage in risky sexual behaviours before, within and outside marriage;
- Explore behaviours and practices that might heighten married young people's, particularly married young women's, vulnerability to STI/HIV and other adverse sexual and reproductive health outcomes, including poor maternal health outcomes and unmet need for contraception; and
- Identify key factors that influence the ability of married young women and men to adopt protective behaviours and practices to reduce STI/HIV risk and, at the same time, make pregnancy safer and address the unmet need for contraception.

Study setting

The study was conducted in two settings: one characterised by low median age at marriage and age at first birth, and *high* prevalence of STI/HIV (Guntur district, Andhra Pradesh), and the second characterised by low median age at marriage and age at first birth, and *low* STI/HIV prevalence (Dhar and Guna districts, Madhya Pradesh) (see Table 1.1 for state-level indicators). The study was located in states with different levels of HIV prevalence, but with similar rates of early marriage and childbearing, to explore the extent to which the vulnerability of married young people to adverse sexual and reproductive health outcomes, including to STI/HIV, and their ability to adopt protective behaviours, vary in settings at different stages of the epidemic, even while such structural factors as age at marriage and childbearing are similar.

Table 1.1:

Marriage and HIV profiles, Andhra Pradesh and Madhya Pradesh, ca. 2005

Characteristic	Andhra Pradesh	Madhya Pradesh
% 20–24 year-old women married by age 18	54.7	53.0
% 25–29 year-old men married by age 21	34.8	54.0
Median age at first birth for women aged 25-49	18.8	19.4
% ever-married 15–49 year-old women who have heard of AIDS	76.0	49.7
% ever-married 15–49 year-old men who have heard of AIDS	93.9	74.4
% ever-married 15–49 year-old women who know that consistent condom use can reduce the chance of getting HIV	34.4	37.8
% ever-married 15–49 year-old men who know that consistent condom use can reduce the chance of getting HIV	68.2	67.1
HIV prevalence rate among women seeking antenatal care	2.0	0.25
HIV prevalence rate among clients attending STD clinics	22.8	0.49

Sources: IIPS and Macro International, 2007b; 2007c; NACO, 2006.

A few key indicators of the study districts are presented in Table 1.2. As can be seen, both Guntur district in Andhra Pradesh, and Dhar and Guna districts in Madhya Pradesh, are characterised by low median age at marriage and first birth. For example, 36 percent of girls aged 15–19 were married in Guntur district; and 40 percent of these girls were mothers (RGI, 2001a). In Dhar district, 34 percent of girls aged 15–19 were married; and 34 percent of these girls were mothers. Similarly, in Guna district, 42 percent of girls aged 15–19 were married; and 26 percent of them were mothers (RGI, 2001a).

Reported levels of risky sexual behaviours vary. In Guntur, for example, 2.5 percent of women seeking antenatal care in rural areas were HIV-positive (APSACS, PFI and PRB, 2005). District-level data are not available for Madhya Pradesh but reported levels of risky sexual behaviours at the state level are relatively low, with, for example, HIV prevalence rates of 0.25 percent among women seeking antenatal care (NACO, 2006).

The two districts of Dhar and Guna in Madhya Pradesh differ considerably in terms of tribal population composition: Dhar is a predominantly tribal district while Guna district is largely non-tribal (55% versus 12%, respectively, of the population in these districts is tribal). Given the significantly large tribal population of Madhya Pradesh (20%), findings were expected to provide a profile of married young women and men from very different socio-cultural settings. For convenience, the data presented here from both sites in Madhya Pradesh are clubbed, thereby providing an average profile of the situation in these heterogeneous settings.

Three blocks, namely, Bhattiprolu, Chilakaluripet and Phirangipuram in Guntur district, and two blocks each, namely, Badnawar and Gandhwani in Dhar district and Aron and Chachaura in Guna district, were selected for the study. These blocks were selected so as to represent variations within districts on one significant socio-demographic indicator, namely, female literacy, an indicator recognised to be closely associated with health outcomes, fertility and age at marriage.

Table 1.2:

Profile of study districts

Characteristic	Guntur	Dhar	Guna
Total population	4,465,144	1,740,329	1,666,767
Overall sex ratio[1]	984	954	885
Child (0–6) sex ratio	959	943	930
Male literacy (%)	57.3	64.0	66.4
Female literacy (%)	42.7	36.0	33.6
Proportion of ever-married 15–19 year-old boys	2.9	9.1	11.1
Proportion of ever-married 15–19 year-old girls	36.0	33.6	42.4
Proportion of married adolescent girls who are mothers	40.0	33.6	25.6
Current contraceptive use among 15–44 year-old women (%)	70.5	52.5	44.2
Full antenatal care (%)[2]	29.4	4.3	3.3
Institutional delivery (%)	64.3	27.9	29.8
Women who are aware of HIV/AIDS (%)	86.8	31.1	29.7

Note: [1] Number of females per1,000 males.
[2] Includes at least three antenatal check-ups, iron and folic acid supplements and at least one tetanus toxoid injection.
Sources: IIPS, 2006; RGI, 2001a; 2001b.

Within these blocks, a certain number of villages were randomly selected for the study. In order to maintain confidentiality and minimise the possibility of conflict arising from the content of the questionnaire, in each block, half the selected villages were assigned for interviewing only females and the other half for interviewing only males; this ensured that married young women and men from the same household were not interviewed.

Study design

A cross-sectional study, comprising a pre-survey qualitative phase and a survey, was conducted among married women aged 15–24 years and married men aged 15–29 years in 27 villages in Guntur district and 42 villages each in Dhar and Guna districts (see Table 1.3 for details). Marriage age distributions required that the age limit for young men be relaxed to 29 years as there was a relative paucity of married young men aged up to 24 years, and those aged 15–29 represented the likely husbands of married young women aged 15–24. Data collection was conducted during June 2005–February 2007.

In the pre-survey qualitative phase, focus group discussions were conducted with married young women and men to explore their perceptions of married young people's risky sexual experiences both before and during marriage; their vulnerability to HIV/AIDS; and their ability to exercise informed choice with regard to adopting protective behaviours, including practising safe sex, ensuring partner notification in case of infection, addressing unmet need for contraception, and reducing the risk of obstetric morbidity and mortality. They were also asked about their views on existing behaviour change communication (BCC) materials and the strategies best suited to conveying messages on actions that could protect them against sexual and reproductive health risks. Findings from the focus group discussions were used to inform the development of the survey instrument.

Table 1.3:
Coverage of the study

Characteristic	Guntur		Dhar & Guna	
	Women	Men	Women	Men
Number of households listed	7,073	7,930	8,315	7,878
Successfully interviewed	6,770	7,332	7,683	7,160
Response rate (%)	95.7	92.5	92.4	90.9
Number of eligible respondents listed	1,694	1,453	2,377	1,990
Successfully interviewed	1,370	1,075	1,717	1,547
Partially interviewed	6	6	7	18
Refused	33	10	19	71
Not at home/postponed	276	355	628	334
Others, including incapacitated	9	7	6	20
Response rate (%)	80.9	74.0	72.2	77.7
Villages covered	13	14	42	42

Survey respondents were identified through a rapid listing of all households in the study area. All usual residents of a household and any visitors who had stayed in the household the night before the interview were listed. For each listed person, information was collected on age, sex, relationship to the head of the household, marital status, years of schooling completed and current work status. All eligible respondents were invited to participate in the survey; however, in households where there was more than one eligible respondent, only one was selected randomly.

The questionnaire drew on a number of existing instruments relating to young people's sexual and reproductive behaviours, awareness, gender role attitudes and agency (IIPS and Population Council, 2002; 2005). It also drew on insights from the pre-survey qualitative phase described above. The instrument was translated into the local languages, Telugu and Hindi. In addition to questions on socio-economic matters, the survey included a range of questions relating to personal characteristics, romantic partnerships, family connectedness and social networks, premarital sexual relationships, marital experiences, extra-marital sexual relationships, awareness of sexual and reproductive matters, family planning practices, experiences of genital tract illness and treatment seeking, and pregnancy and childbirth. Recognising the reluctance of respondents to disclose premarital and extra-marital sexual experiences in a survey situation, at the conclusion of the interview, all respondents were asked two additional questions ("Have you ever had sex before marriage with anyone?" and "Have you ever had sex with anyone other than your wife/husband after marriage?"), and were required to mark a tick or cross on two separate blank sheets of paper, place the sheets in two separate envelopes, seal them and hand them to the interviewer. Respondents were informed that the envelopes would not be opened in the field, and that only the principal investigator would be able to link the information provided in the envelope to the questionnaire.

Investigators and supervisors were recruited locally, and training workshops were held for five days for investigators involved in conducting focus group discussions and for 10 days for those involved in conducting the survey. To ensure the quality of data collection, field supervisors regularly supervised and monitored the fieldwork, field-edited the completed questionnaires, carried out spot-checks of interviews and assisted investigators as required.

Refusal rates were low; however, the data collection team was not able to reach a substantial proportion of identified respondents mainly because they were not at home at the time of the interview. In both settings, work-related temporary migration was significant among young men. Although young women were not affected by such migration, in both sites, married young women tended to move frequently between their marital and natal homes during the initial months of marriage, and young pregnant women tended to return to their natal home for the first delivery and period thereafter.

Characteristics of respondents' households

Table 1.4 presents a profile of the households in which young people reside. Several context-specific differences were evident: in both settings, for example, the majority of female and male respondents were Hindus; however, in Guntur, Muslims and Christians also constituted a sizeable proportion of both the female and male samples. Among the Hindus, the proportion of scheduled castes and scheduled tribes was higher in Dhar and Guna than in Guntur.

Table 1.4:

Socio-demographic profile of respondents' households

Characteristic (%)	Guntur		Dhar & Guna	
	Women (N=1,370)	Men (N=1,075)	Women (N=1,717)	Men (N=1,547)
Religion				
Hindu	56.7	66.7	98.6	98.1
Muslim	11.2	10.5	1.2	1.6
Christian	32.0	22.8	0.1	0.0
Others	0.1	0.0	0.2	0.7
Caste/tribe*				
Scheduled caste	5.1	16.5	17.7	15.6
Scheduled tribe	8.5	13.9	34.6	37.6
Other backward castes	42.6	37.9	31.4	34.7
General caste[1]	42.7	31.7	12.9	8.6
Household amenities				
Own toilet	35.1	38.6	6.3	8.1
Gas/electricity for cooking	18.9	26.3	1.8	1.7
Own water facilities	19.3	10.0	10.5	8.8
Mean number of consumer goods owned[2]	3.2	3.2	2.5	2.8
Parents' education				
Ever attended school, father	38.3	29.5	28.0	29.6
Ever attended school, mother	18.0	13.7	6.4	4.7

*Note; *Among those who reported they were Hindus. For the purpose of analysis, scheduled tribes were included within the Hindu category; those who reported that they did not know their caste/tribe were not included.*
[1]Includes those who do not belong to scheduled castes, scheduled tribes or other backward castes.
[2]Scale ranges from 0 to 14.

Characteristics of respondents

The socio-demographic characteristics of respondents, summarised in Table 1.5, reflect substantial gender and site-specific differences. Age profiles show that, as expected, female respondents were younger than male respondents; while young women in both settings were on average of similar ages, young men in Guntur were 1–2 years older than those in Dhar and Guna. Although both settings are characterised by early marriage, findings also show that young women and men in Dhar and Guna were more likely to be married at younger ages than were their counterparts in Guntur (the median age at first marriage being 15 and 16 years among females, and 19 and 21 years among males, respectively). In both settings, as expected, husbands were older than their wives: 4–5 years older in Guntur and about 2–4 years older in Dhar and Guna. Data on school enrolment and years of schooling completed indicate that young women were less educated than young men; however, the gender gap in these indicators was wider in Dhar and Guna than in Guntur. Moreover, both young women and men in Guntur were better educated than their counterparts in Dhar and Guna.

Young women were more likely to have engaged in unpaid work than young men, but less likely to

Table 1.5:

Socio-demographic profile of respondents

Characteristic	Guntur		Dhar & Guna	
	Women (N=1,370)	Men (N=1,075)	Women (N=1,717)	Men (N=1,547)
Age				
Mean age	20.3	25.5	20.0	23.6
Age at marriage				
Median age at first marriage	16	21	15	19
Spousal age difference				
Median spousal age difference	5	4	4	2
Educational status				
Ever enrolled in school (%)	66.5	73.1	31.5	67.2
Mean years of schooling completed	4.7	5.6	1.9	5.5
Current work status				
Unpaid work in the last 12 months (%)	15.6	6.5	45.8	7.5
Paid work in the last 12 months (%)	50.2	99.9	46.0	92.9
Type of family				
Nuclear (%)	45.6	40.7	36.5	28.1

have engaged in paid work. While a larger proportion of young women in Guntur were engaged in paid work than in unpaid work, a similar proportion of young women in Dhar and Guna were engaged in both paid and unpaid work. Irrespective of study setting, the majority of young women and men lived in non-nuclear families. However, young women were more likely than young men to report that they lived in nuclear families. Moreover, the proportion of young women and men who lived in nuclear families was larger in Guntur than in Dhar and Guna.

Structure of the report

This report is structured as follows. Chapter 2 examines young women's and men's sexual experiences before, within and outside marriage. Chapter 3 discusses respondents' experiences of genital tract infection, their treatment seeking and the extent of HIV testing. Chapter 4 explores the behaviours and practices that heighten the vulnerability of married young women to adverse reproductive outcomes, including early and unplanned pregnancies, and poor maternal health outcomes. Chapter 5 describes the factors underlying married young people's ability to adopt protective sexual and reproductive health behaviours, which would reduce their risk of acquiring HIV and other STIs, and of experiencing early and unplanned pregnancies, and pregnancy-related complications. Chapter 6 summarises the key findings of the study and suggests programmatic recommendations.

CHAPTER 2

Sexual experiences before, within and outside marriage

This chapter describes findings on married young women's and men's premarital romantic and sexual partnerships and extra-marital sexual relationships, and the extent to which sexual experiences before, within and outside marriage were safe and consensual.

Premarital romantic partnerships

The survey included a number of questions to assess the experience of romantic partnerships among young women and men: these included whether a proposal for friendship had been made to or received from an opposite sex person that was accepted, whether the respondent had met an opposite sex friend secretly and whether the respondent had a boy/girlfriend. Youth who responded positively to any of the above were defined to have had a premarital romantic partner. Findings presented in Figure 2.1 show that romantic partnerships before marriage were not uncommon among young women and men in both settings. As expected, young women were less likely to report that they had a romantic partner before marriage than young men, with fewer than one in 10 young women compared to more than one in four young men reporting so.

Figure 2.1:
Extent of premarital romantic partnerships

*Note: * Romantic partner includes those who had made or received a proposal for friendship that was accepted, had met an opposite sex friend secretly or had a boy/girlfriend.*

Significant gender differences were evident with regard to age at initiation into romantic partnerships; females were more likely to be initiated into romantic partnerships at younger ages than young men, an obvious consequence of their earlier age at marriage (see Table 2.1). In both settings, about three-fifths of young women who had a premarital romantic relationship reported that their relationship had started at age 15 or below. In contrast, only one-tenth of young men in Guntur and one-third in Dhar and Guna reported a first romantic partnership at age 15 or below.

In both settings, a sizeable proportion of young women and men who had engaged in premarital romantic partnerships reported that their first partner was from the same neighbourhood. However, significant gender differences were evident in each setting. In Guntur, young men were more likely to report someone from the neighbourhood as the first romantic partner than young women (59% and 34%, respectively). In Dhar and Guna, the reverse pattern was noted; young women were more likely to report that their first premarital romantic partner was from the neighbourhood than were young men (48% and 35%, respectively). Setting-specific and gender differences were evident with regard to other types of romantic partners as well. For example, young women and men in Guntur were more likely to report a relative as the first romantic partner than were their counterparts in Dhar and Guna, and within each setting, young women were more likely to report a relative than young men (44% and 19% of young women and men, respectively, in Guntur versus 18% and 9%, respectively, in Dhar and Guna). In contrast, young women and men in Dhar and Guna were more likely to report someone outside their neighbourhood as the first romantic partner than their counterparts in Guntur. Of note also is that young women were less likely than young men to report a fellow student or colleague as the first romantic partner in both settings, particularly in Dhar and Guna.

The majority of young women in both settings, particularly in Guntur, reported that their first romantic partner was older than them. For example, 91 percent of young women in Guntur and 53 percent in Dhar and Guna reported that their partner was at least two years older than them; and in Guntur, over one in 10 young women reported that their first romantic partner was at least 7 years older. In contrast, less than 5 percent of young men in both settings reported that their partner was older than them. Partners were typically unmarried in both settings. However, one-tenth of young men in Guntur and about one-tenth of young women in Dhar and Guna reported that their first romantic partner was married.

Gender differences were also evident with regard to the number of partners reported by those who had premarital romantic partnerships. Young women were less likely to report having had more than one partner than young men in both settings; differences were wider in Guntur than in Dhar and Guna. While only 2 percent of young women in Guntur who had a romantic partnership reported more than one partner, one-third of young men reported so; in contrast, in Dhar and Guna, one-tenth of young women compared to over one-fourth of young men reported so.

Findings also indicate that the majority of young women and men who reported a romantic partnership had engaged in a range of intimate behaviours with the romantic partner, from holding hands to kissing on the lips to sexual intercourse. However, in both settings, young women were somewhat less likely than young men to report any of these experiences—about or more

Table 2.1:

Characteristics of premarital romantic partnerships

Characteristic (%)	Guntur		Dhar & Guna	
	Women (N=105)*	Men (N=297)*	Women (N=104)*	Men (N=453)*
Had first romantic partnership at age 15 or below	58.1	9.8	61.5	32.0
Relationship of first romantic partner to respondent				
Someone from the neighbourhood	34.3	59.3	48.1	35.3
Relative	43.8	18.9	18.3	8.6
Classmate or colleague	10.5	13.2	8.7	20.3
Someone outside the neighbourhood	1.9	4.7	14.4	33.6
Teacher, employer, employee	1.0	0.6	1.9	0.2
Family friend	6.7	1.7	3.8	0.0
Previously unknown person	1.9	0.0	1.9	1.5
Age difference with first partner				
Partner younger (2–8 years)	1.0	60.3	1.9	32.0
Partner about the same age (1 year older or younger)	6.7	33.7	22.1	61.4
Partner older (2–6 years)	79.0	2.7	47.1	3.1
Partner much older (7+ years)	12.4	1.3	5.8	0.2
Marital status of first partner				
Unmarried	96.2	87.5	86.5	94.5
Married	3.8	10.8	8.7	4.4
Divorced/separated/widowed	0.0	0.3	0.0	0.0
Had more than one romantic partner	1.9	32.0	10.6	29.1
Experience of physical intimacy				
Ever held hands	78.1	91.6	84.6	88.5
Ever hugged	49.5	85.2	71.2	81.9
Ever kissed on the lips	43.8	71.4	68.3	77.9
Ever had sexual intercourse	42.9	70.0	55.8	70.6
Experienced any of the above	78.1	91.6	85.6	90.1

*Note: * Includes those who reported premarital romantic partnerships. Percentages do not add up to 100 because of missing responses.*

than 80 percent of young women compared to 90 percent of young men. Such gender differences were far wider in Guntur than in Dhar and Guna. Among young women and men, reporting of intimate behaviours declined steadily with increasing forms of intimacy; this was more evident in Guntur than in Dhar and Guna. What is notable is that of those who reported a premarital romantic relationship, some seven in 10 young men, irrespective of setting, had proceeded to engage in sexual relations with their partner. Among women too, while considerably lower, large proportions of those who had a premarital romantic relationship reported engaging in sexual relations with the partner: more than two in five young women in Guntur and over half of those in Dhar and Guna.

Findings on the nature of sexual relations reported by those who had engaged in sex with a romantic partner suggest significant gender differences in both settings (see Table 2.2); however, as only a few young women reported sexual experiences in a romantic partnership, findings need to be interpreted with caution. Setting-specific differences were narrow in the case of young women but considerable with regard to young men. For example, in both settings, as in the case of formation of romantic partnerships, young women were more likely than young men to have experienced first sex with a romantic partner at a younger age; indeed, over half of young women in both settings who reported sex with a boyfriend had engaged in sex at age 15 or below. In contrast, fewer than 10 percent of young men in Guntur and a little over one-fourth in Dhar and Guna had done so.

The study also enquired into the consensuality of first sex with a romantic partner. While most young women and men in both settings reported that their first sex with a romantic partner was consensual, notable setting-specific and gender differences were evident. Young women and men in Guntur were more likely to report that first sex was consensual than their counterparts in Dhar and Guna. In both settings, as expected, young women were more likely than young men to report that they were persuaded or forced into first sex; one-tenth of young women in Guntur and over one-fourth in Dhar and Guna, compared to 1 percent or fewer young men in both settings. At the same time, 2 percent of young men in both settings reported forcing their partner to engage in sex the first time, and 6 percent and 24 percent, respectively, in Guntur and in Dhar and Guna, reported persuading their partner to engage in sex the first time. Findings also indicate that condom use was virtually non-existent in both settings; although there were some site-specific differences, fewer than 10 percent of young women and men who had engaged in sexual relations with a romantic partner reported condom use at first sex or regular condom use with their romantic partner.

Table 2.2:

Nature of sexual relations within premarital romantic partnerships

Characteristic (%)	Guntur		Dhar & Guna	
	Women (N=45)*,[1]	Men (N=206)*	Women (N=58)*	Men (N=320)*
Had first sex with a romantic partner at age 15 or below	(53.3)	8.3	58.6	28.4
Consensuality of first sexual experience				
Consensual	(86.7)	90.8	67.2	73.8
Respondent was persuaded	(6.7)	0.5	15.5	0.3
Respondent was forced	(4.4)	0.5	13.8	0.0
Respondent persuaded partner	(2.2)	6.3	3.4	24.1
Respondent forced partner	(0.0)	1.9	0.0	1.6
Condom use				
Used condom at first sex with a romantic partner	(4.4)	2.9	8.6	5.9
Used condoms with romantic partner/s	(2.2)	1.5	5.2	2.5

*Note: * Includes those who reported sexual experiences within romantic partnerships.*
[1]Percentages are based on a small number of cases, and hence findings need to be interpreted with caution.

Premarital sexual experiences within romantic and non-romantic partnerships

In order to assess the extent of premarital sexual experiences among young women and men within romantic and non-romantic partnerships, respondents were asked questions relating to sex with an array of sexual partners. We acknowledge that, in spite of detailed probing by trained investigators, young women and men might have under-reported sexual experiences. As noted earlier, in order to give respondents an opportunity to disclose premarital sexual experiences anonymously, a sealed but linked envelope reporting system was adopted by which respondents marked their response in privacy and placed the response card in an accompanying sealed envelope. Findings are presented in Table 2.3.

Findings show that despite norms proscribing premarital sexual activity, a number of young women and men had engaged in such relationships. As expected, young men were more likely to have experienced premarital sexual relationships than young women in both settings—one-third of young men compared to just 5 percent of young women reported any premarital sexual experience. And while anonymous reporting did indeed enable a few respondents to disclose sexual activity, it did not increase overall reporting substantially.

No significant differences by setting were evident with respect to the overall prevalence of premarital sexual relationships among young women and men. However, wide differences were reported in relation to the range of partners with whom young men engaged in sex: while a romantic partner was most likely to be cited

Table 2.3:

Extent and type of premarital sexual experiences within romantic and non-romantic partnerships

Characteristic (%)	Guntur		Dhar & Guna	
	Women (N=1,370)	Men (N=1,075)	Women (N=1,717)	Men (N=1,547)
Type of sexual experience				
Sex with romantic partner	3.3	19.3	3.4	20.7
Sex with spouse-to-be	1.5	2.0	1.0	1.0
Sex with same-sex partner	0.0	0.6	0.1	1.6
Forced to have sex by someone other than romantic/ same-sex partner	0.1	1.1	0.2	0.3
Sex in exchange for job/promotion/gifts	0.1	0.8	0.1	0.4
Sex worker relations	N/A	6.3	N/A	2.1
Sex with older married woman	N/A	4.7	N/A	1.7
Casual sex	0.3	3.1	0.1	1.7
Face-to-face reporting of any premarital sex	3.8	28.3	4.0	24.3
Anonymous reporting of any premarital sex	4.5	30.0	4.0	25.9
Anonymous or face-to-face reporting of any premarital sex	5.0	31.9	4.9	29.1

Note: N/A: Question not asked.

by all, young men in Guntur were more likely to have reported sexual experiences with sex workers, older married women or casual partners than their counterparts in Dhar and Guna (12% versus 5%).

Findings presented in Table 2.4 indicate that sizeable proportions of young people who had premarital sexual experiences had engaged in risky sexual behaviours. For example, a substantial proportion of young people, particularly young women (for reasons noted earlier), had experienced first sex at an early age, that is, at age 15 or below. Among sexually experienced young women, more than one-half in Guntur and about two-thirds in Dhar and Guna had experienced first sex at age 15 or below. In contrast, over one-tenth of sexually experienced young men in Guntur and over one-fourth in Dhar and Guna had initiated sex at age 15 or below.

In both settings, one-third of young men who had premarital sexual experiences reported multiple partner relationships. Among females, while only 2 percent in Guntur reported multiple partners, as many as 10 percent in Dhar and Guna reported so.

Table 2.4:

Nature of premarital sexual experiences within romantic and non-romantic partnerships

Characteristic (%)	Guntur		Dhar & Guna	
	Women (N=52)*	Men (N=304)*	Women (N=68)*	Men (N=376)*
Had first sex at age 15 or below	55.8	12.2	63.2	27.1
More than one sexual partner	1.9	37.2	10.3	33.8
Type of first sexual partner/experience				
Romantic partner	78.8	63.2	75.0	80.3
Spouse-to-be	9.6	0.3	16.2	1.6
Same-sex partner	0.0	1.3	1.5	4.8
Forced sex[1]	1.9	2.3	4.4	0.8
Sex in exchange for job/promotion/gifts	1.9	0.7	0.0	0.3
Sex worker relations	N/A	15.8	N/A	4.5
Older married woman	N/A	9.5	N/A	4.0
Casual sex	7.7	6.9	2.9	3.7
Consensuality of sex[2]				
Ever experienced forced sex	7.7	6.3	17.6	1.6
Ever perpetrated forced sex	0.0	1.6	0.0	1.3
Condom use[3]				
Ever used condoms in any premarital sexual relations	5.8	15.5	7.4	11.4
Always used condoms in all types of premarital sexual relations	1.9	6.6	2.9	2.9

*Note: * Includes those who reported premarital sexual experiences in face-to-face interviews; those who reported such experiences only anonymously were excluded.*
[1]Includes forced sex by partners other than a romantic or same-sex partner.
[2]Questions on consensuality of sex were asked only with regard to first sexual experience with a romantic partner and/ or a same-sex partner and any forced experience with any other premarital sexual partner.
[3]Questions on condom use were asked only with regard to sexual relationships with a romantic partner/s, sex worker, married woman, casual partner, transactional sexual relationships and first sexual experience with a same-sex partner.
N/A: Question not asked.

Data also show significant setting-specific and gender differences in the type of first sexual partner/ experience. In both settings, about 90 percent of young women reported that their first sexual experience was with a boyfriend or husband-to-be. The majority of young men in both settings also reported that their first sexual partner was a girlfriend or wife-to-be; however, the percentage who reported so was larger in Dhar and Guna than in Guntur. Of note is that a significant minority reported a sex worker or an older married woman as their first sexual partner, particularly in Guntur; one-fourth of young men in Guntur compared to one-tenth in Dhar and Guna. Also notable is that, though reported by a small number of respondents in both settings, young women and men in Guntur (8% and 7%, respectively) were more likely to report a casual partner as the first sexual partner than their counterparts in Dhar and Guna (3% and 4%, respectively).

Findings indicate that substantial proportions of premarital sexual experiences were coercive. Significant setting-specific differences were evident in the reporting of coercive experiences among young women; in Dhar and Guna young women were more likely to report such experiences than in Guntur (18% versus 8%). Of note is that 6 percent of young men in Guntur also reported having experienced forced sex before marriage. Fewer than 2 percent of young men in both settings reported that they had perpetrated coercive sex before marriage.

Data also indicate that condom use in premarital sexual relationships was limited in both settings. In Guntur, 16 percent of young men and 6 percent of young women reported ever using condoms in any premarital sexual relationship, while in Dhar and Guna, 11 percent of young men and 7 percent of young women reported so. Far fewer young women and men in both settings reported that they always used condoms in all types of premarital sexual relationships.

Sexual experiences within marriage

While sexual relations within marriage, unlike premarital sexual experiences, have social sanction, marriage does not inherently make sex safe or voluntary, particularly for young women. As findings presented in Table 2.5 show, substantial proportions

Table 2.5:

Cohabitation status and age at cohabitation

Characteristic (%)	Guntur		Dhar & Guna	
	Women (N=1,370)	Men (N=1,075)	Women (N=1,717)	Men (N=1,547)
Cohabitation status				
No *gauna*[1]	0.0	0.1	5.5	3.0
No *gauna,* but initiated sexual relations with spouse	0.0	0.0	0.6	3.2
Cohabiting	100.0	99.9	93.5	93.7
Age at cohabitation				
Cohabited at age 15 or below	44.5	0.6	37.4	3.2
Cohabited before the legal age at marriage*	72.7	38.2	73.8	56.7
Median age at cohabitation	16.0	21.0	16.0	20.0

Note: [1]Ceremony marking initiation into cohabitation.
**Among females aged 18 and above and males aged 21 and above.*

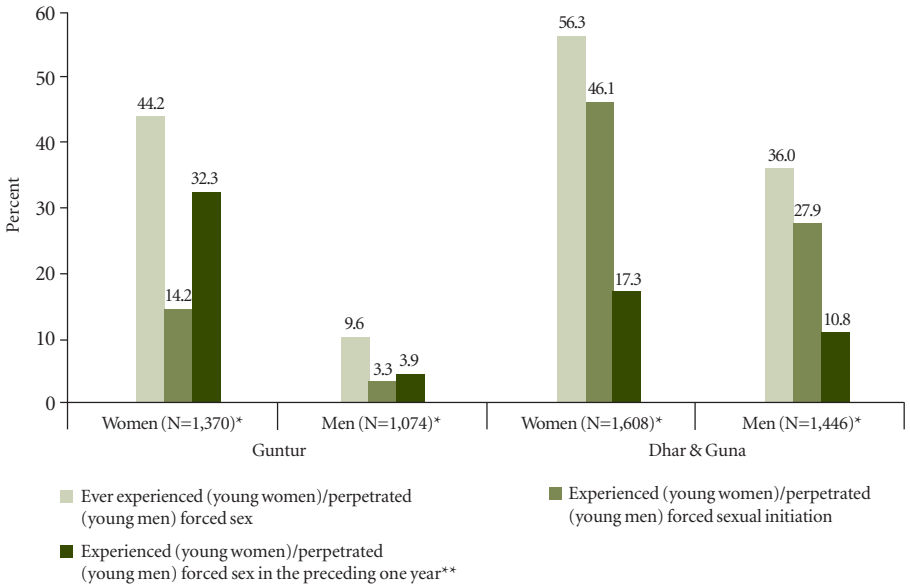
of young women had initiated sex within marriage at a young age in both settings, particularly in Guntur; 45 percent of young women in Guntur and 37 percent in Dhar and Guna had begun cohabiting at age 15 or below. Moreover, about three-fourth of young women in both settings had cohabited before they reached the age of 18, the legal age at marriage for girls in India. Conversely, only a small number of young men in both settings had cohabited at age 15 or below; however, about two-fifths of young men in Guntur and three-fifths in Dhar and Guna had cohabited before they reached the age of 21, the legal age at marriage for boys in India.

As can be seen from Figure 2.2, forced sexual experiences within marriage were widespread in both settings. Data on lifetime experience or perpetration of forced sex within marriage show that young women in Guntur were somewhat less likely to report such experiences as compared to young women in Dhar and Guna (44% versus 56%). Similarly, young men in Guntur were less likely to report that they had ever perpetrated forced sex on their spouse than young men in Dhar and Guna (10% versus 36%).

Respondents were also asked about forced sexual initiation within marriage and their recent experiences of forced sex, that is, in the 12 months preceding the interview. A substantial proportion of young women, particularly in Dhar and Guna, reported forced sexual initiation within marriage (46% in Dhar and Guna compared to 14% in Guntur). While many fewer men reported perpetrating forced first sex, the regional pattern is similar: 28 percent and 3 percent of young men in Dhar and Guna, and in Guntur, respectively, reported

Figure 2.2:

Extent of sexual coercion within marriage experienced by young women and perpetrated by young men



*Note: *Includes those who had begun cohabiting.*
*** Includes those who have cohabited for at least a year.*

perpetrating forced sexual initiation within marriage. Findings also indicate that forced sexual experiences continued later in married life. However, while significant setting-specific variations were evident, the regional pattern was different: data indicate that young women in Guntur were more likely to have experienced forced sex recently than young women in Dhar and Guna (32% versus 17%). Thus, while fewer women had ever experienced forced sex in Guntur, they were more likely to continue to experience forced sexual relations; in Dhar and Guna, in contrast, although more women reported ever experiencing forced sexual relations, such experiences were less likely to continue on a sustained basis. As with the reporting of lifetime perpetration of forced sex, young men in Guntur were less likely to report that they had coerced their wives to have sex in the year preceding the survey than young men in Dhar and Guna (4% versus 11%).

In both settings, the use of condoms within marriage was rare. In Guntur, in particular, despite being a high HIV prevalence setting, only 1 percent of young women and men reported that they had ever used condoms within marriage, either to delay pregnancy or to prevent STIs (Table 2.6). In comparison, 5 percent of young women and 18 percent of young men in Dhar and Guna reported ever use of condoms within marriage. These contextual differences in condom use within marriage are corroborated by findings from RCH district-level surveys, which indicate that condom use as reported by women aged 15–44 was particularly limited in Guntur (0.1%), and was somewhat higher in Dhar and Guna (5–7%) (IIPS, 2006).

In both settings, those who ever used condoms reported using condoms primarily to delay pregnancy rather than to prevent infections. Few young women and men in both settings reported that they were currently using condoms; however, 9 percent of young men in Dhar and Guna reported current use of condoms within marriage.

Extra-marital sexual experiences

As in the case of premarital sex, respondents were asked about extra-marital sexual experiences in the course of face-to-face interviews as well as through anonymous reporting. Findings indicate that even though not as prevalent as premarital sexual

Table 2.6:

Condom use within marriage

Characteristic (%)	Guntur		Dhar & Guna	
	Women (N=1,370)*	Men (N=1,074)*	Women (N=1,608)*	Men (N=1,446)*
Ever used condoms to delay pregnancy or prevent STIs	1.2	0.7	5.0	17.8
Ever used condoms to delay pregnancy	1.1	0.7	4.9	16.7
Ever used condoms to prevent STIs	0.2	0.0	0.9	4.4
Currently using condoms	0.4	0.2	2.5	9.0

*Note:*Includes those who had begun cohabiting.*

Table 2.7:

Extent and type of extra-marital sexual experiences

Characteristic (%)	Guntur		Dhar & Guna	
	Women (N=1,370)	Men (N=1,075)	Women (N=1,717)	Men (N=1,547)
Type of extra-marital sexual experience				
Sex with romantic partner	2.3	5.1	0.8	3.0
Sex with same-sex partner	N/A	0.1	N/A	0.3
Forced to have sex by someone other than romantic/ same-sex partner	0.1	0.6	0.2	0.1
Sex in exchange for job/promotion/gifts	0.4	0.1	0.0	0.0
Sex worker relations	N/A	1.2	N/A	1.1
Sex with older married woman	N/A	2.8	N/A	1.1
Casual sex	0.7	1.0	0.9	1.6
Face-to-face reporting of any extra-marital sex	3.3	8.8	2.0	6.7
Anonymous reporting of any extra-marital sex	4.2	10.4	2.0	8.1
Anonymous or face-to-face reporting of any extra-marital sex	4.8	11.5	3.0	9.6
Reporting of extra-marital sex in the last 12 months	1.9	4.2	0.6	2.8

Note: N/A: Question not asked.

partnerships, a small minority of young women and men in both settings had engaged in extra-marital sexual relationships (Table 2.7). As expected, young women were less likely than young men to report such experiences; 5 percent or less of young women in both settings compared to one-tenth of young men reported such experiences. Far fewer reported extra-marital experiences in the year preceding the survey.

In both settings, almost all young women who had extra-marital sexual experiences reported only one extra-marital sexual partner (96–97%) (Table 2.8). In contrast, differences by setting were wider: 17 percent of young men in Guntur compared to 10 percent in Dhar and Guna reported having had sex with more than one extra-marital sexual partner.

Extra-marital sexual experiences were coercive for a small number of young women; 9 percent of young women in Guntur and 12 percent in Dhar and Guna who reported extra-marital sexual experiences reported that they were forced to have extra-marital sex. Of note also is that some 6 percent of young men in Guntur and 2 percent in Dhar and Guna who reported extra-marital sexual experiences reported that they were forced to have sex. While not a single female respondent in either setting, or any male respondent in Guntur, reported perpetration of forced sex on an extra-marital partner, 3 percent of young men in Dhar and Guna reported having forced their extra-marital partner to have sex with them.

Findings also indicate that condom use in extra-marital relationships was limited in both settings; while gender differences were marked, setting-specific differences were narrow. Young men were considerably more likely than young women to

Table 2.8:

Nature of extra-marital sexual experiences

Characteristic (%)	Guntur		Dhar & Guna	
	Women (N=45)*,[1]	Men (N=95)*	Women (N=34)*,[1]	Men (N=103)*
Had more than one extra-marital sexual partner	(4.4)	16.8	(2.9)	9.7
Consensuality of sex[2]				
Experienced forced sex	(8.9)	6.3	(11.8)	1.9
Perpetrated forced sex	(0.0)	0.0	(0.0)	2.9
Condom use[3]				
Ever used condoms in any extra-marital sexual relations	(8.9)	27.4	(8.8)	23.3
Always used condoms in all types of extra-marital sexual relations	(8.9)	10.5	(5.9)	13.6

*Note: * Includes those who reported any extra-marital sexual experiences in face-to-face interviews; those who reported such experiences only anonymously were excluded.*
[1] Percentages are based on a small number of cases, and hence findings need to be interpreted with caution.
[2] Questions on consensuality of sex were asked only in relation to first sexual experience with an extra-marital romantic and/ or same-sex partner and any forced experience with any other extra-marital sexual partner.
[3] Questions on condom use were asked only with regard to sexual relationships with an extra-marital romantic partner, sex worker, married woman (for male respondents), casual partner, transactional sexual partnerships and first experience after marriage with a same-sex partner.

report using condoms in extra-marital relationships (23–27% of young men compared to 9% of young women who reported extra-marital sexual experiences). Among young women, the proportion of respondents who reported that they always used condoms in all types of extra-marital sexual relationships was roughly similar to those who reported ever use of condoms, probably due to the fact that most women who reported extra-marital sexual relations had such experiences only once with a single partner. However, among young men, considerably smaller proportions—just over 10 percent—reported consistent use compared to ever use of condoms in extra-marital relationships.

CHAPTER 3

Self-reported symptoms of infection and treatment seeking

This chapter describes the extent to which married young women and men experienced symptoms of genital tract infection, sought treatment for these symptoms and took action to prevent the transmission of infection to their spouses. It also explores whether respondents had undergone an HIV test, and the reasons for opting to do so.

Symptoms of genital tract infection experienced and related treatment seeking

Respondents were asked whether they had experienced symptoms of genital tract infection in the 12 months preceding the survey, and the extent to which they had sought curative care or taken preventive action to minimise the potential risk of transmitting the infection to their spouses. Findings presented in Table 3.1 show that, in both settings, with the exception of young women from Dhar and Guna, only a small proportion of young women and men reported experiencing such symptoms as genital ulcers, itching in the genitals, swelling in the groin or bad-smelling urethral or vaginal discharge: less than 5 percent of young women and men in Guntur and about one-tenth of young men in Dhar and Guna, compared to over one-fourth of young women in Dhar and Guna. While the factors underlying the considerable disparity in reports of bad-smelling discharge among women in the two settings warrant further exploration, findings from NFHS-2, indicating that about 13 percent of married young women in these states reported the experience of "abnormal" discharge (IIPS and ORC Macro, 2000), suggest the possibility of some under-reporting in Guntur and over-reporting in Dhar and Guna.

As can be seen from Table 3.1, treatment seeking among those who experienced genital symptoms was limited in both settings, particularly in Dhar and Guna. For example, while over half of young women and men in Guntur who experienced such symptoms sought treatment, only a little over one-fifth of young women and one-third of young men in Dhar and Guna did so. In both settings, seeking treatment promptly, that is, as soon as symptoms were noticed, was uncommon, particularly in Dhar and Guna: one-fifth of young women and one-fourth of young men in Guntur sought treatment promptly, compared to about one-tenth in Dhar and Guna.

Few respondents who experienced symptoms of infection took action to prevent transmission to their spouses. For example, while over half of those in Guntur and fewer in Dhar and Guna reported that they had informed their spouses about the symptoms, only a few had asked their spouses to go for a check-up—no more than 16 percent in either setting. Far fewer reported that their spouses had indeed gone for a check-up; 12–14 percent in Guntur and less than one-tenth in Dhar and Guna. Similarly, few respondents reported that they either abstained from sex or used condoms while having sex when they experienced genital symptoms: 19 percent of young women from Guntur and fewer than 10 percent of those from the remaining three groups.

Table 3.1:

Symptoms of genital tract infection experienced in the last 12 months, treatment seeking and preventive actions adopted

Symptoms experienced (%)	Guntur		Dhar & Guna	
	Women (N=1,370)	Men (N=1,075)	Women (N=1,717)	Men (N=1,547)
Genital ulcers, itching in the genitals, swelling in the groin	2.9	2.6	9.0	6.3
Bad-smelling urethral/vaginal discharge	2.1	0.2	26.8	2.8
Any of the above	4.2	2.6	28.8	8.3
Of those who experienced symptoms, % who:	**Women (N=58)**	**Men (N=28)[1]**	**Women (N=494)**	**Men (N=128)**
Sought treatment	51.7	(64.3)	22.9	32.8
Sought treatment promptly (as soon as symptoms were noticed)	19.0	(25.0)	8.3	10.9
Informed spouse about symptoms	62.1	(50.0)	45.1	36.7
Asked spouse to go for a check-up	15.5	(10.7)	9.9	14.8
Spouse went for a check-up	12.1	(14.3)	5.7	7.8
Used condoms while having sex with spouse/abstained from sex	19.0	(7.1)	3.2	6.3

Note: [1]Percentages are based on a small number of cases and hence findings need to be interpreted with caution.

HIV testing

The study also collected information on whether respondents had ever had an HIV test and the reasons for undergoing the test.[1] As expected, because Guntur is a high HIV prevalence setting, a larger proportion of young women and men in Guntur than in Dhar and Guna reported having had an HIV test (Table 3.2). In Guntur, one-half of young women and one-sixth of young men had undergone an HIV test. The reasons cited for undergoing the test varied: among those who had taken the test, almost all the women (96%) had undergone the test as part of regular antenatal check-ups. In contrast, more than half of all men reported that they had taken the test to establish their HIV status, a little more than one-fourth had been encouraged by a provider to undergo the test and another one-fourth cited reasons related to blood donation, surgery and symptoms of illness for undergoing the test. In Dhar and Guna, only 1 percent or fewer young women and men had undergone an HIV test; most of these respondents reported that they had taken the test to establish their HIV status.

[1]*The study did not enquire as to whether those who had undergone an HIV test had received the test result or not.*

Table 3.2:

HIV testing and reasons cited for undergoing an HIV test

Characteristic (%)	Guntur		Dhar & Guna	
	Women (N=1,370)	Men (N=1,075)	Women (N=1,717)	Men (N=1,547)
Had an HIV test	49.3	16.7	0.3	1.0
Of those who had been tested for HIV, reasons cited for undergoing the test:[1]	**Women (N=675)**	**Men (N=179)**	**Women (N=5)[2]**	**Men (N=16)[2]**
As part of an antenatal check-up	96.3	N/A	(0)	N/A
To know their HIV status	0.9	57.0	(2)	(6)
Experienced risky premarital sex	0.1	3.9	(1)	(0)
Asked by spouse to do so	0.1	4.5	(1)	(0)
Concerned about spouse's HIV status	0.1	0.0	(0)	(0)
Encouraged by peers	0.1	6.7	(0)	(0)
Encouraged by provider	1.5	27.9	(1)	(3)
Others[3]	1.0	24.6	(1)	(1)

Note: [1] Multiple responses are presented.
[2] Figures in brackets are numbers.
[3] Including blood donation, surgery and illness.
N/A: Not applicable.

CHAPTER 4

Contraception, maternal health practices and service utilisation

This chapter focuses on behaviours and practices that heighten the vulnerability of married youth, particularly married young women, to adverse reproductive outcomes, including early and unplanned pregnancies and poor maternal health outcomes.

Contraceptive practices, timing of first pregnancy/birth and unmet need for contraception

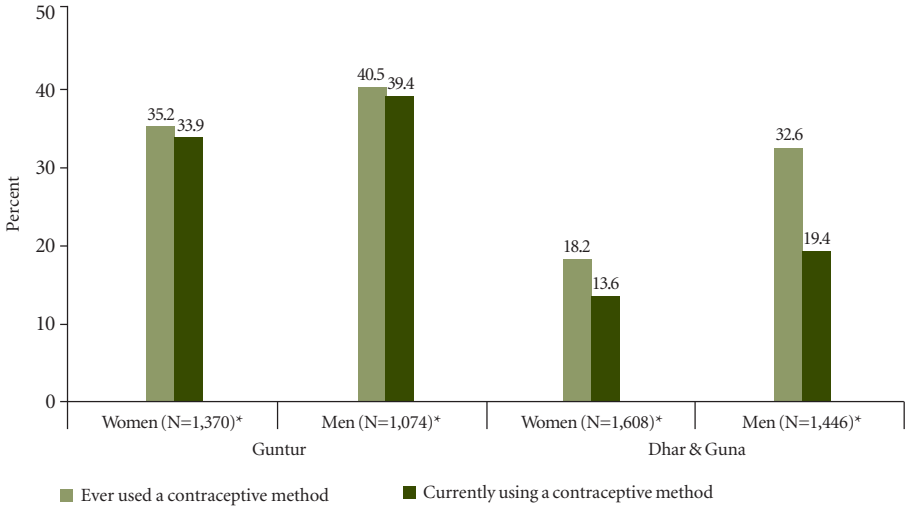
This section presents findings on ever and current use of contraceptive methods within marriage, and the extent to which these methods were used prior to the first pregnancy. It also describes respondents' desires and experiences with regard to timing of the first pregnancy/ birth, and the extent to which the most recent pregnancy was unplanned.

Contraceptive practices

The use of contraceptive methods within marriage was far from universal in both settings; no more than two in five respondents reported ever use of contraceptive methods in any of the study groups (Figure 4.1). Gender and setting specific differences were evident. In both locations, young men were more likely than young women to report that they had ever used a contraceptive method within marriage; and young women and men in Guntur were more likely to report ever use of contraceptive methods than their counterparts in Dhar and Guna.

Figure 4.1:

Ever use and current use of contraceptive methods within marriage



*Note: * Includes those who had begun cohabiting.*

Setting-specific differences were noted with respect to the contraceptive method first used within marriage. In Guntur, about one-third of all women who cohabited (92% of ever-users) and nearly two-fifths of all men who cohabited (94% of ever-users) reported that the method that they/their wives, first used was female sterilisation (Table 4.1). Even though not as widely used as in Guntur, female sterilisation was the first method used by the largest proportion of young women in Dhar and Guna as well; about one-tenth of all women who cohabited (49% of ever-users) reported doing so. In contrast, among young men in Dhar and Guna, the condom was most frequently reported as the first contraceptive method used within marriage, with about one-fifth of all men who cohabited (53% of ever-users) reporting so. Current method use—dominated by the large number of females/wives sterilised—reflected a similar distribution. Indeed, the current contraceptive rates observed in the study are comparable to the rates calculated using data from NFHS-3 for currently married young women and men in the states of Andhra Pradesh and Madhya Pradesh.

Timing of first pregnancy/ birth

The discussion on the timing of first pregnancy or birth is limited to those who reported that they were cohabiting, and that they or their wives had ever become pregnant (i.e., 82% and 78% of the total female and male samples in Guntur, and 77% and 74% in Dhar and Guna, respectively). Findings indicate significant setting-specific differences in married young people's desires regarding the timing of the first pregnancy (Table 4.2). In Guntur, no more than one in five young women and men reported that they had wanted to delay the first pregnancy, possibly

Table 4.1:

Contraceptive practice in marriage: Method first used and method currently being used

Method used (%)	Guntur		Dhar & Guna	
	Women (N=1,370)*	Men (N=1,074)*	Women (N=1,608)*	Men (N=1,446)*
Method first used within marriage[1]				
Female sterilisation	32.3	38.1	8.9	6.8
Condom	0.7	1.1	4.7	17.2
Oral contraceptive pill	1.1	0.7	2.1	6.0
Intra-uterine device (IUD)	0.7	0.1	0.4	0.3
Other methods	0.4	0.5	0.6	0.8
Method currently being used[1]				
Female sterilisation	32.6	38.5	9.5	8.5
Condom	0.4	0.2	2.5	9.0
Oral contraceptive pill	0.5	0.4	1.1	1.9
Intra-uterine device (IUD)	0.2	0.1	0.2	0.2
Other methods	0.3	0.3	0.4	0.4

*Note: * Includes those who had begun cohabiting.*

[1] Percentages do not total 100 as those who had never used a contraceptive method or were currently not using a contraceptive method are not included in the table.

because of the common practice of completing the family building process at younger ages (the median age at sterilisation was 23.6 years in 1998–99 among women in Andhra Pradesh) (IIPS and ORC Macro, 2000). In contrast, in Dhar and Guna, over one-third of young women and men reported a desire to delay the first pregnancy. Despite these preferences, it is notable that of those who desired to delay first pregnancy, only a few reported that they had practised some form of contraception before the first pregnancy. No more than 3 percent of young women in both settings, and young men in Guntur, reported practising contraception to delay the first birth; however, in Dhar and Guna, 17 percent of young men who wanted to delay the first pregnancy reported contraceptive use before the first pregnancy. Findings from NFHS-2 also show that the use of contraceptive methods among zero parity young women is almost non-existent in these states (less than 1.0% of 15–24 year-old women with no living children in rural Andhra Pradesh and 2.5% in Madhya Pradesh reported contraceptive use) (IIPS and ORC Macro, 2000).

Given that not many young people desired to delay the first pregnancy, and only a small proportion of young women and men used contraceptive methods before the first pregnancy, it is not surprising that a substantial proportion of young women became mothers at a young age. Two in five young women in Guntur and one in three in Dhar and Guna had their first birth by age 18. Far fewer young men in both setting (one in four young men in Guntur and one in five in Dhar and Guna) reported that their wives had their first birth by age 18.

Extent of unplanned pregnancy

All respondents who reported at least two births, or one live birth and a current pregnancy, were also asked whether the last pregnancy was planned. Given the limited use of contraceptives among study participants, it is not surprising that sizeable proportions reported that the most recent pregnancy was either mistimed or unwanted (Figure 4.2). About equal proportions of young women and men in both settings reported that the most recent pregnancy was unwanted.

Table 4.2:

Timing of first pregnancy/birth

Characteristic (%)	Guntur		Dhar & Guna	
	Women	Men	Women	Men
Wanted to delay first pregnancy*	17.5 (N=1,122)	19.8 (N=834)	36.3 (N=1,317)	37.3 (N=1,136)
Ever used a contraceptive method before first pregnancy**	2.6 (N=196)	3.0 (N=165)	2.3 (N=478)	17.0 (N=424)
Women who had/young men whose wives had first delivered by age 18***	39.3 (N=1,148)	25.6 (N=998)	32.5 (N=1,383)	20.2 (N=1,352)

*Note: *Among those who/whose wives had ever become pregnant.*
***Among those who/ whose wives had ever become pregnant and who desired to delay the first pregnancy.*
**** Among women/ young men whose wives were aged 18 or above at the time of the survey and were cohabiting.*
Data on age at first birth are missing for 21,7,15 and 29 cases from young women's and men's samples in Guntur, and Dhar and Guna, respectively.

However, setting-specific differences in reports of mistimed pregnancy were wide. Young women and men in Guntur were somewhat less likely to report a mistimed recent pregnancy than were their counterparts in Dhar and Guna. For example, 17 percent of young women in Guntur compared to 35 percent in Dhar and Guna reported that their most recent pregnancy was mistimed. Similarly, 8 percent of young men in Guntur compared to 26 percent in Dhar and Guna reported that their wives' most recent pregnancy was mistimed. The finding that unplanned pregnancy was more likely to be reported by respondents from Dhar and Guna than from Guntur is corroborated by findings on lower rates of contraceptive use; among respondents who reported two or more births, or one live birth and a current pregnancy, only 25 percent and 42 percent of young women and men in Dhar and Guna, compared to 64 percent and 78 percent, respectively, in Guntur, reported ever use of contraceptives (not shown in tabular form).

Maternal health practices and utilisation of services

The study explored the extent to which young women and the wives of young men sought routine maternal health services during the antenatal, delivery and postpartum period for their first and most recent births, as applicable. Data were also gathered on the extent to which treatment was sought for pregnancy-related complications for these births. This analysis is restricted to those respondents who reported at least one live or still birth (i.e., 74% and 71% of the female and male samples in Guntur, and 71% and 69% in Dhar and Guna, respectively). The following analysis reports primarily on health care seeking for the first birth, that is, the birth most likely to pose health risks to the woman. Findings related to the second or higher order births are discussed briefly, as appropriate.

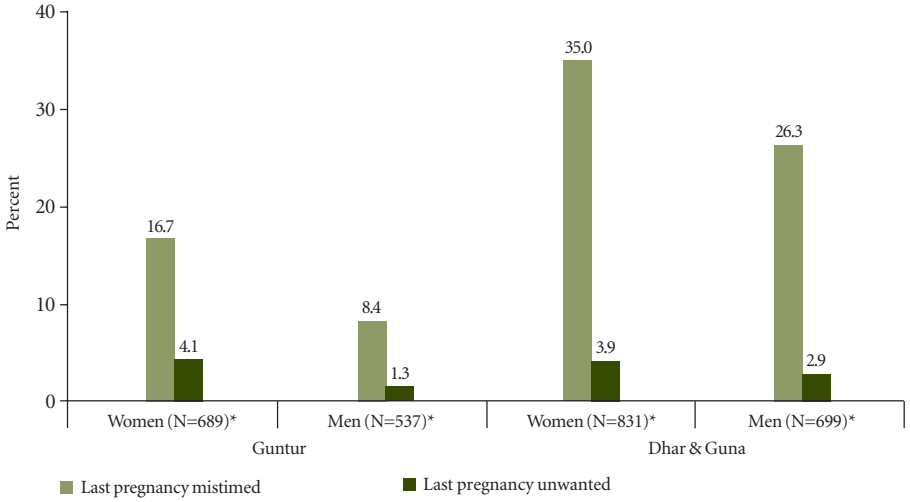
Maternal health care seeking during pregnancy, delivery and the postpartum period for the first birth

Significant setting-specific differences were evident with regard to maternal health care seeking for the first birth. For example, while almost all married young women in Guntur had received at least some antenatal care, no more than 63 percent of women and 45 percent of men in Dhar and Guna reported that they/their wives had obtained some antenatal care at the time of the first pregnancy (Figure 4.3). Similarly, setting-specific differences were evident with regard to the quality of antenatal check-ups received. For example, while no less than 74 percent of respondents in Guntur reported that they/their wives received at least three antenatal check-ups, only 26 percent or fewer respondents in Dhar and Guna reported so. Likewise, while 58 percent and 46 percent of women and men in Guntur reported that they/ their wives had received comprehensive antenatal check-ups, only 17 percent and 12 percent, respectively, from Dhar and Guna did so.

Similar setting-specific differences were noted with regard to the practice of institutional delivery and skilled attendance at birth (Figure 4.4). For example, while nearly three-fourths of young women and men in Guntur reported that the first delivery took place in a health facility, only a little over one-third in Dhar and Guna reported so. In both settings, particularly in Dhar and Guna, postpartum care seeking after the first birth was limited among those who had a non-institutional delivery (Figure 4.5). In Guntur, about one-third of young women who had a non-institutional delivery, and one-half of young men whose wives had a non-institutional delivery, reported that they/ their wives had received a health check-up within 40 days of delivery. In comparison, fewer than 10 percent of respondents in Dhar and Guna reported so.

Figure 4.2:

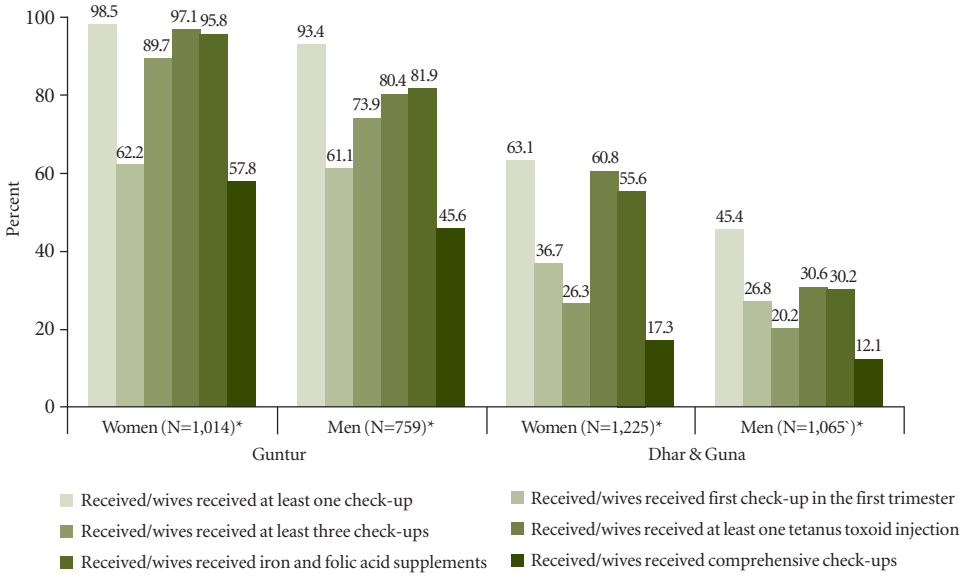
Extent of unplanned pregnancy



*Note: * Includes those who reported more than one live birth, or one live birth and a current pregnancy.*
Data are missing for 4, 2, 5 and 19 cases from young women's and men's samples in Guntur, and Dhar and Guna, respectively.

Figure 4.3:

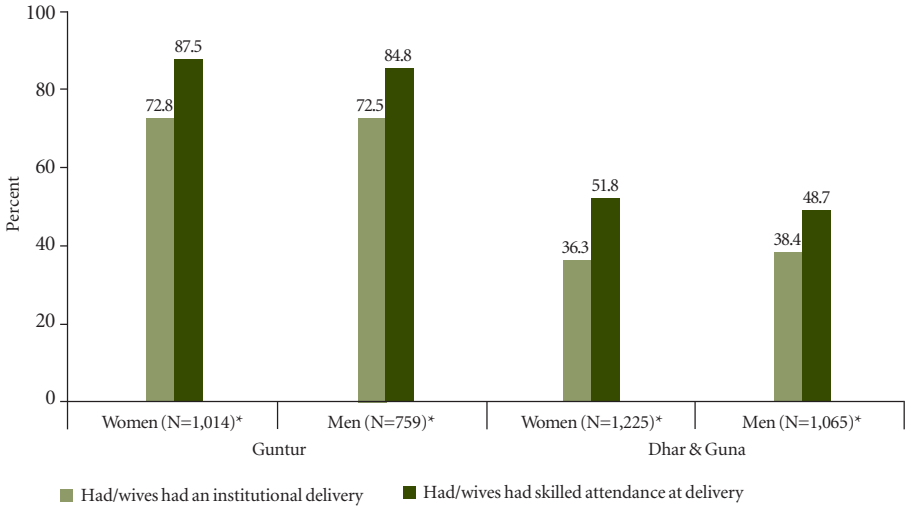
Extent of antenatal care seeking during the first pregnancy



Note: Includes those who/whose wives had at least one live or still birth.*

Figure 4.4:

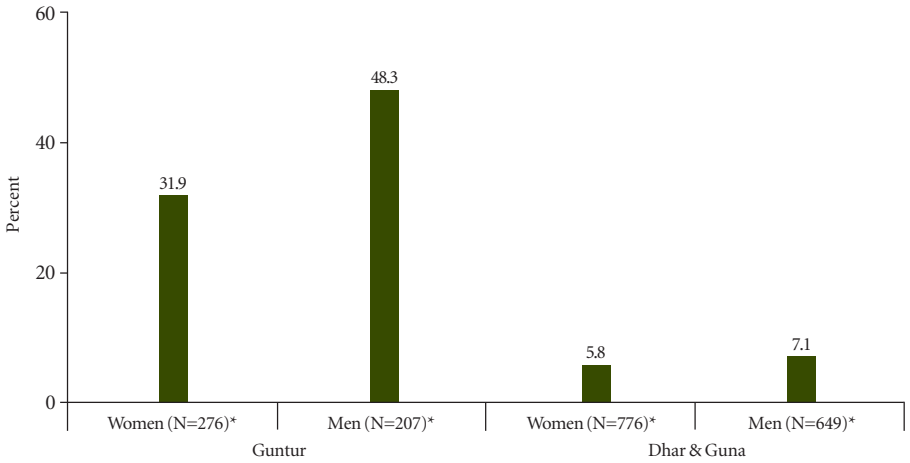
Extent of care seeking at delivery: Institutional delivery and skilled attendance at first birth



*Note: * Includes those who/whose wives had at least one live or still birth.*

Figure 4.5:

Extent of care seeking after first birth



*Note: * Includes those who/whose wives had at least one live or still birth and had a non-institutional delivery.*

Among women who had more than one birth, data show that care seeking during the antenatal period and at delivery for the second and higher order births was even more limited than for the first birth. However, postpartum check-ups appeared to be more common in relation to the second or higher order births than for the first birth (not shown in tabular form).

Treatment seeking for pregnancy-related complications during the first birth

A substantial proportion of young women and men in both settings, but particularly in Dhar and Guna, reported that they/their wives had experienced at least one pregnancy-related complication during pregnancy, delivery or the postpartum period for the first birth (Table 4.3). For example, over one-fifth of young women in Guntur compared to more than one-half in Dhar and Guna reported having experienced at least one complication. Similarly, 18 percent of young men in Guntur compared to 24 percent in Dhar and Guna reported that their wives had experienced one or more complications.

Seeking treatment for pregnancy-related complications was far more common in Guntur than in Dhar and Guna. While over 80 percent of young women and men who reported a pregnancy-related problem had sought treatment, only one-half of young women and about two-thirds of the wives of young men in Dhar and Guna had done so.

Table 4.3:

Complications experienced during pregnancy, delivery and the postpartum period for the first pregnancy and treatment sought

Complication (%)	Guntur		Dhar & Guna	
	Women (N=1,014)*	Men (N=759)*	Women (N=1,225)*	Men (N=1,065)*
High blood pressure or blurred vision	5.2	2.9	23.9	11.4
Swelling of hands, legs or face	9.6	11.1	25.6	11.5
High fever	3.6	2.5	22.6	9.2
Heavy bleeding (life-threatening)	2.7	1.4	5.7	3.2
Prolonged labour	9.0	4.6	13.2	5.4
Any of the above	22.6	17.8	51.8	23.6
Of those who reported experiencing a complication, % who:	**Women (N=229)**	**Men (N=135)**	**Women (N=634)**	**Men (N=251)**
Sought treatment	87.8	85.9	49.5	64.1

*Note: * Includes those who/ whose wives had at least one live or still birth.*

CHAPTER 5

Factors underlying vulnerability to HIV and other sexual and reproductive health risks

A number of factors are hypothesised to influence married young people's ability to adopt protective behaviours and practices to reduce their risk of acquiring STI/HIV and, at the same time, make pregnancy safer and address their unmet need for contraception. This chapter describes these factors, notably, young people's awareness and in-depth knowledge of sexual and reproductive health matters, their attitudes towards protective actions and their perceptions of personal risk. It also explores young people's agency within marriage, prevailing gender norms, couple communication, family and social support, and access to information and services on sexual and reproductive health.

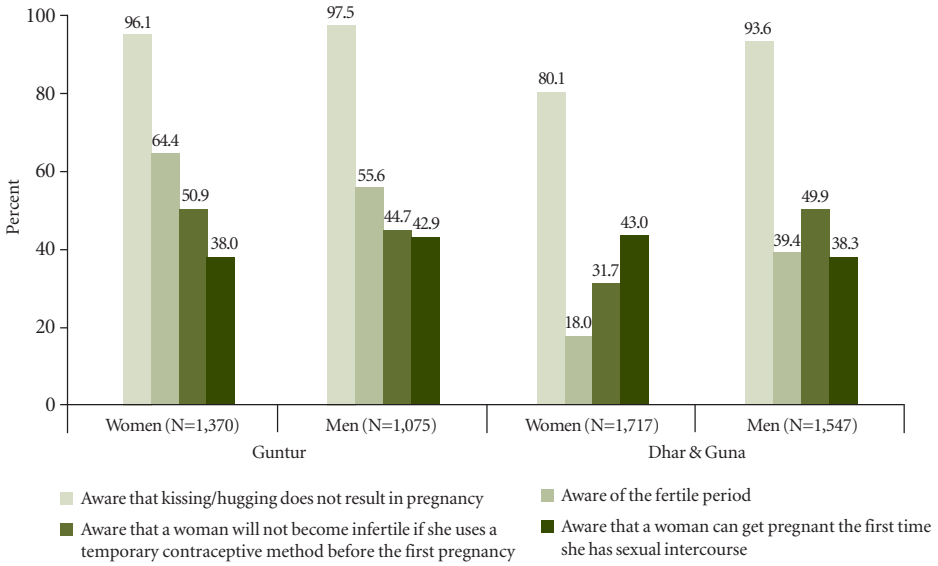
Awareness and knowledge of sexual and reproductive health matters

Young women and men were asked a series of questions pertaining to sexual intercourse and pregnancy, contraceptive methods, pregnancy-related care and STIs/HIV/AIDS to assess their awareness and knowledge of sexual and reproductive health matters. Findings confirm that in-depth awareness on most topics was limited.

Knowledge of sexual intercourse and pregnancy

Four questions were posed to respondents to assess their knowledge of sexual intercourse and pregnancy (see Figure 5.1). Findings show that in-depth

Figure 5.1:
Knowledge of sexual intercourse and pregnancy



knowledge was limited among young women and men in both settings. For example, no more than 43 percent of young women and men in Guntur and in Dhar and Guna were aware that a woman can get pregnant the first time she has sexual intercourse. Likewise, no more than 50 percent of respondents in Guntur and Dhar and Guna knew that a woman will not become infertile if she uses a non-terminal contraceptive method before her first pregnancy. In general, young women and men from Guntur were better informed as compared to young people in Dhar and Guna, particularly young women (a mean score of 2.4–2.5 versus a mean score of 1.7–2.2).

Knowledge of contraceptive methods

While awareness of at least one contraceptive method was universal among all categories of respondents except young men in Dhar and Guna (even so, 86% were aware), findings indicate that knowledge of specific methods, particularly those that are suitable to young people, was not as widespread (Figure 5.2).

Gender differences were notable; young women were more likely to be aware of female methods than young men and vice-versa. For example, 64 percent and 37 percent of young women from Guntur and 72 percent and 30 percent of young women in Dhar and Guna had heard of oral contraceptives and IUDs, respectively, compared to 53 percent and 11 percent of young men in Guntur, and 57 percent and 25 percent of young men in Dhar and Guna, respectively. In contrast, 97 percent and 80 percent of young men in Guntur and Dhar and Guna, respectively, had heard of condoms as compared to 70 percent and 65 percent of young women in these settings.

In-depth knowledge of contraceptive methods was also limited in both settings, but setting-specific differences were evident (Table 5.1). For example, despite the fact that over 60 percent of young women in both settings were aware of oral contraceptive pills, only one-sixth of young women in Guntur and less than one-half in Dhar and Guna knew how frequently a woman should take these pills. Similarly, while more

Figure 5.2:

Awareness of contraceptive methods

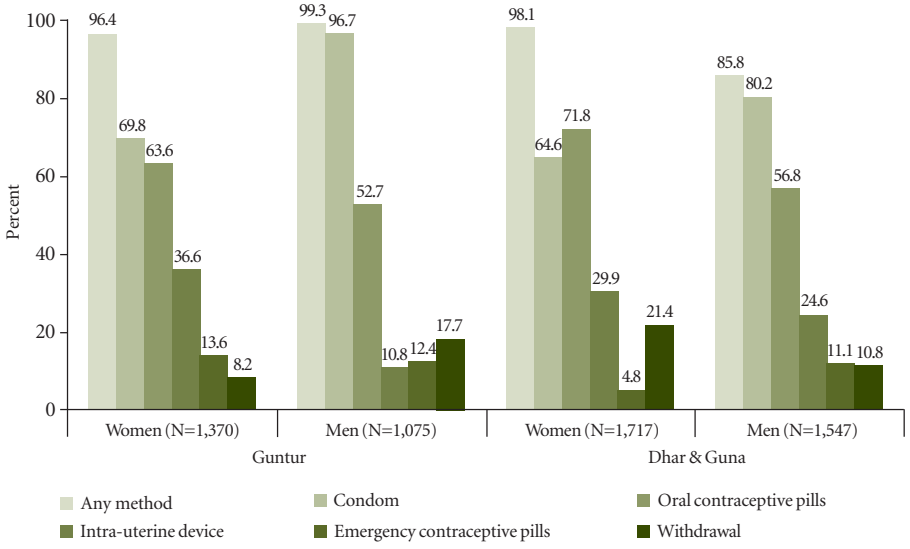


Table 5.1:

In-depth awareness of contraceptive methods, and awareness of spacing methods before marriage

% reporting that they are aware of the following:	Guntur		Dhar & Guna	
	Women (N=1,370)	Men (N=1,075)	Women (N=1,717)	Men (N=1,547)
How frequently oral contraceptive pills should be taken	16.4	17.5	46.8	34.5
How soon after sex should emergency contraceptive pills be taken	1.3	1.6	2.4	3.4
When a man should pull out of a woman during intercourse	4.2	16.5	17.8	10.1
Where an IUD is inserted in a woman's body	16.3	4.5	18.0	9.4
A condom can be used for just one act of sexual intercourse	20.6	81.2	46.4	74.1
The condom is a suitable method for preventing pregnancy	52.7	93.8	49.6	68.8
Condoms do not slip off the man during intercourse and disappear inside a woman's body	18.0	38.6	31.9	45.1
Condoms can prevent the transmission of STIs	48.5	84.5	22.3	39.0
Dual protection methods	41.5	81.8	15.3	31.0
Mean score (0–9 scale)	**2.20**	**4.20**	**2.51**	**3.15**
Awareness before marriage:				
Aware of spacing methods	22.4	72.9	25.3	42.0
Aware of where to get contraceptive supplies	14.4	68.5	17.0	39.7

than one-half of young men in both settings were aware of oral contraceptive pills, only one-sixth of young men in Guntur and one-third of young men in Dhar and Guna were correctly informed about the frequency of taking these pills. Likewise, although some two-thirds of young women had heard of condoms in both settings, only one-fifth of young women in Guntur and less than one-half of young women in Dhar and Guna were aware that a condom can be used only once. In short, young women in Guntur were far more lacking in in-depth knowledge about various contraceptive methods, except about the benefits of condoms, as compared to young women in Dhar and Guna. Young men in Guntur were far more knowledgeable about condoms than their counterparts in Dhar and Guna.

The study also explored young people's awareness of spacing methods before marriage. As can be seen from Table 5.1, few young women—no more than one-fourth—were aware of spacing methods before marriage in both settings. Even fewer were aware of places where they could get contraceptive supplies before marriage. In contrast, larger proportions of young men were aware of spacing methods and sources of such methods before marriage in both settings, particularly in Guntur; about three-fourths of men in Guntur were aware of spacing methods and over two-thirds about where to acquire supplies before marriage, compared to about two-fifths in Dhar and Guna.

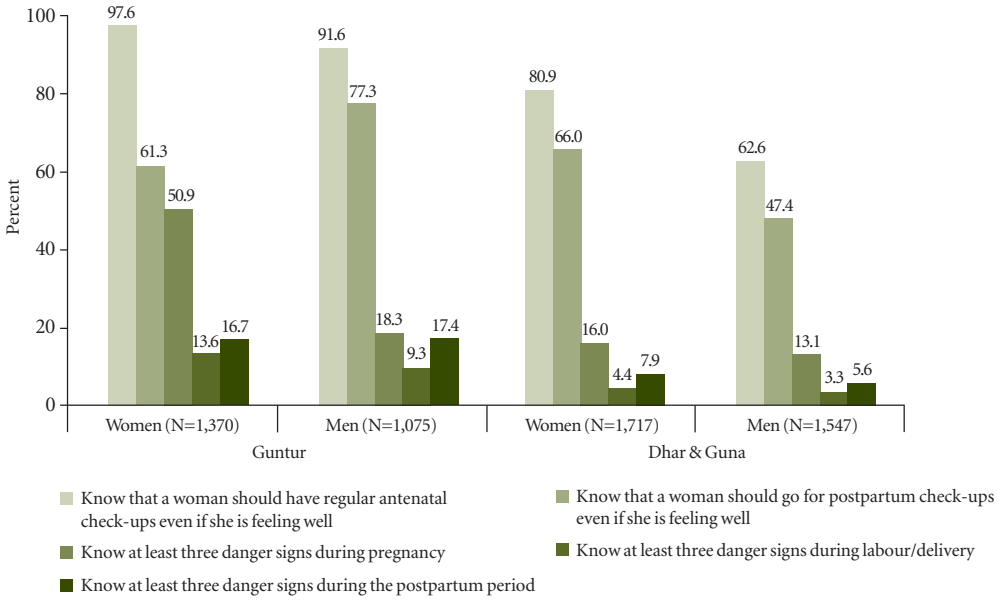
Knowledge of pregnancy-related care

Respondents were asked a series of questions to assess their knowledge of pregnancy-related care and the danger signs during pregnancy, delivery and the postpartum period. Significant gender and setting-specific differences were evident with regard to knowledge of pregnancy-related care (Figure 5.3). Young women were better informed about these issues than young men in each setting, and young people in Guntur were better informed than their counterparts in Dhar and Guna. The extent of knowledge varied by topic. Awareness of the importance of regular antenatal check-ups was widespread in both settings, particularly in Guntur. For example, over 90 percent of young women and men in Guntur compared to 81 percent and 63 percent of young women and men, respectively, in Dhar and Guna knew that a woman should have regular check-ups during pregnancy even if she is feeling well. However, far fewer were aware that a woman should go for postpartum check-ups even if she is feeling well. In Guntur, young men were more likely to be aware of the need for postpartum check-ups than were young women (77% and 61%, respectively); in Dhar and Guna, in contrast, young women were relatively better informed than young men (66% and 47%, respectively).

Findings varied with regard to knowledge of danger signs during pregnancy, delivery and the postpartum period. For one, all respondents, irrespective of setting or gender, were more likely to be aware of the danger signs in pregnancy than during delivery or the postpartum period. Second, for the most part, more young women than men reported awareness of at least three danger signs during pregnancy, delivery and the postpartum period.

Figure 5.3:

Knowledge of pregnancy-related care and danger signs during pregnancy, delivery and the postpartum period



Knowledge of HIV/AIDS and STIs

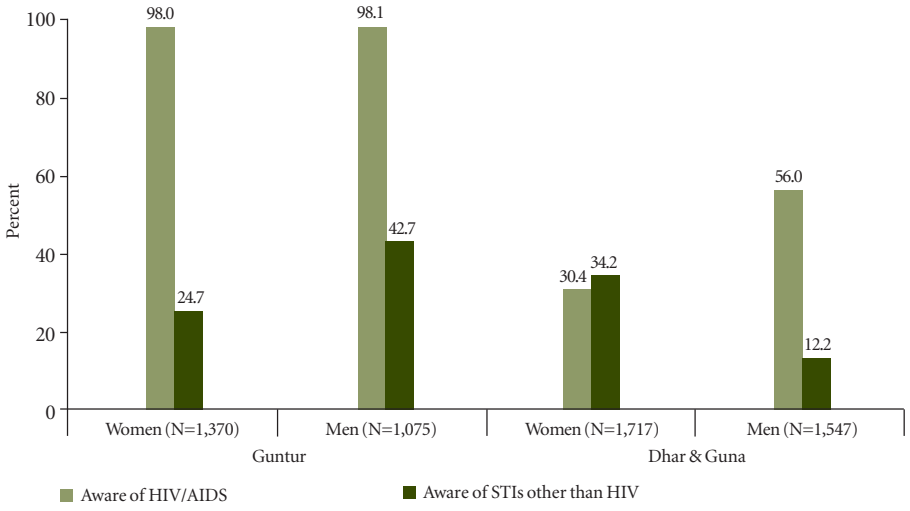
Not surprisingly, given that Guntur is a high HIV prevalence setting, larger proportions of young women and men in Guntur than in Dhar and Guna had heard of HIV/AIDS (98% of young women and men in Guntur versus 30% and 56%, respectively, in Dhar and Guna; see Figure 5.4). Correspondingly, larger proportions of young women and men in Guntur than in Dhar and Guna were aware of ways of preventing the transmission of HIV. For example, 83 percent and 79 percent of young women and men, respectively, in Guntur, compared to 22 percent and 47 percent, respectively, in Dhar and Guna, were aware that having just one sexual partner can reduce the chances of getting HIV (Table 5.2). Likewise, 51 percent and 82 percent of young women and men, respectively, in Guntur, compared to 16 percent and 45 percent, respectively, in Dhar and Guna, were aware that consistent condom use can reduce the likelihood of acquiring HIV.

Consequently, misconceptions regarding the transmission of HIV were less prevalent among young women and men in Guntur than in Dhar and Guna. For example, 77 percent and 68 percent of young women and men, respectively, in Guntur were aware that one cannot tell whether a person is HIV-positive by looking at him/her compared to 25 percent and 50 percent of young women and men, respectively, in Dhar and Guna. Misconceptions were by and large less prevalent among young men than women in both settings.

Awareness of places where a person can go for an HIV test was also more widespread in Guntur than in Dhar and Guna, and among young men than among women in both settings. Seventy percent of young women in Guntur compared to 6 percent in Dhar and Guna knew about HIV testing facilities; similarly, 81 percent of young men in Guntur compared to 21 percent in Dhar and Guna were aware of testing facilities.

Figure 5.4:

Awareness of HIV/AIDS and STIs



Compared to those who were aware of HIV generally, far fewer respondents had heard of other STIs, even in Guntur. For example, in Guntur, 25 percent and 43 percent of young women and men, respectively, were aware of STIs compared to 98 percent who were aware of HIV (Figure 5.4). Similarly, in Dhar and Guna, only 12 percent of young men had heard of STIs compared to 56 percent who had heard of HIV. The only exception was that of young women in Dhar and Guna, where a slightly larger proportion reported awareness of STIs other than HIV—34 percent compared to 30 percent.

Awareness of symptoms of STIs and the importance of partner check-ups in cases where the spouse has an STI was limited in both settings. Of note is that while young women were less aware of the symptoms of STIs than young men in Guntur, the reverse pattern was evident in Dhar and Guna. For example, in Guntur, only 16 percent of young women compared to 38 percent of young men were aware of at least one symptom of STI. Corresponding percentages for Dhar and Guna were 33 and 11. Similar differences were noted with respect to awareness of the importance of partner check-up if the spouse has an STI.

The mean scores of responses to nine questions assessing knowledge of HIV and other STIs, and the location of testing facilities, highlight the gender and setting-specific nature of awareness: in both settings, young men scored roughly 1–2 points more than young women, and respondents in Guntur scored roughly three points more than those of the same sex in Dhar and Guna.

Table 5.2:
In-depth awareness of HIV/AIDS and STIs

% aware of the following:	Guntur		Dhar & Guna	
	Women (N=1,370)	Men (N=1,075)	Women (N=1,717)	Men (N=1,547)
One can reduce the chances of getting HIV by having just one partner	83.1	79.3	22.0	46.9
One can reduce the chances of getting HIV by using condoms regularly	50.7	81.7	16.4	45.1
HIV is not transmitted by mosquito bites	52.0	71.7	17.6	36.5
HIV cannot be transmitted by sharing food with an HIV-positive person	67.4	89.5	16.8	48.4
HIV cannot be transmitted by hugging an HIV-positive person	68.3	88.6	20.4	48.5
One cannot tell whether a person has HIV by looking at him/her	76.6	68.4	24.6	50.0
Where one can go for an HIV test	69.5	80.7	6.3	20.6
At least one symptom of STIs	15.8	38.2	33.0	10.5
It is important for a woman/man to go for a check-up if the spouse has an STI	22.8	41.6	12.9	9.6
Mean score (0–9 scale)	**5.06**	**6.40**	**1.70**	**3.16**

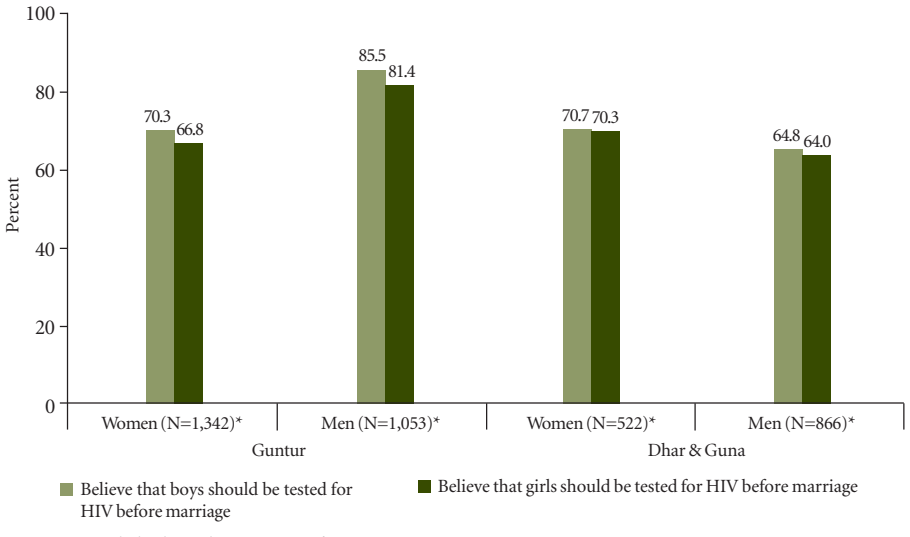
Attitudes towards protective actions

The study explored young people's attitudes towards selected protective actions, namely, premarital HIV testing and the use of condoms within marriage. Significant setting-specific and gender differences were evident in young people's attitudes towards premarital HIV testing (Figure 5.5). Roughly similar proportions of young women in both Guntur and Dhar and Guna agreed that girls and boys should be tested for HIV before marriage; 67–70 percent of those young women who were aware of HIV (that is, 65–69% of all women) in Guntur, and 70–71 percent of those who were aware of HIV (that is, 21–22% of all women) in Dhar and Guna reported so. However, among young men, a larger proportion in Guntur than in Dhar and Guna agreed about the need for premarital testing for both boys and girls; 81–86 percent of those who were aware of HIV (80–84% of all men) in Guntur compared to 64–65 percent of those who were aware of HIV (36% of all men) in Dhar and Guna reported so. Also notable were gender differences within settings among those who were aware of HIV: while larger proportions of young men than women agreed about the need for premarital HIV testing in Guntur, the reverse pattern was observed in Dhar and Guna.

In contrast, young people's attitudes towards condom use within marriage were more unfavourable in Guntur than in Dhar and Guna (Figure 5.6). For example, 40–47 percent of those who were aware of condoms (33–39% of all young people) in Guntur agreed that only sex workers and unfaithful persons should use condoms. In comparison, just 10–16 percent of those who were aware of condoms (7–12% of all young people) in Dhar and Guna believed so. Of note also is that larger proportions of respondents in Guntur than in Dhar and Guna reported that they (male respondents) or their husbands (female respondents) would be angry if the wife asked the

Figure 5.5:

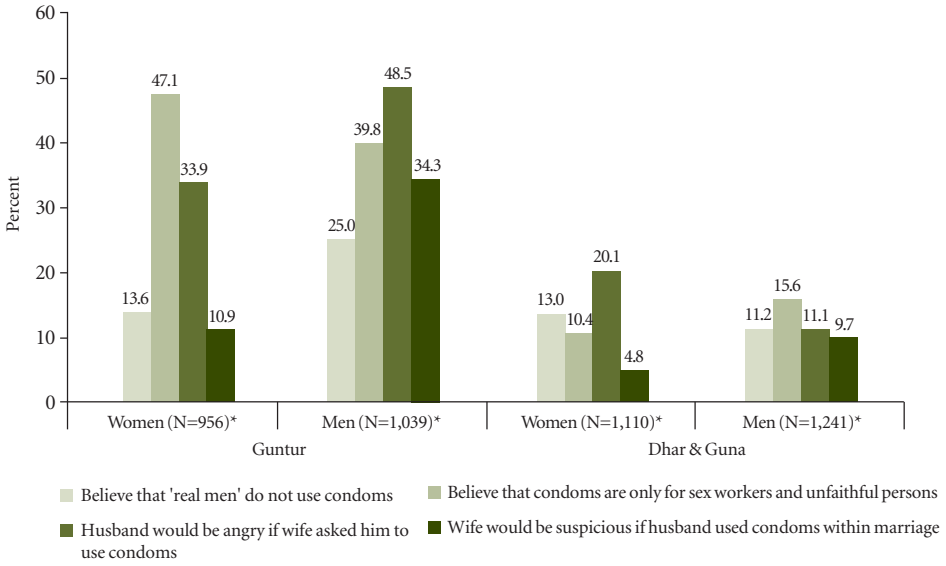
Attitudes towards premarital HIV testing



*Note: * Includes those who were aware of HIV.*

Figure 5.6:

Attitudes towards condom use within marriage



*Note: *Includes those who were aware of condoms.*

husband to use a condom—34–49 percent of those who were aware of condoms (24–47% of all young people) in Guntur compared to 11–20 percent of those who were aware of condoms (9–13% of all young people) in Dhar and Guna. Fears that the wife would suspect her husband of being unfaithful if he used a condom within marriage were also more likely to be expressed by respondents from Guntur than Dhar and Guna; 11–34 percent of those who were aware of condoms (8–33% of all young people) in Guntur compared to 5–10 percent of those who were aware of condoms (3–8% of all young people) in Dhar and Guna. Gender differences were also remarkable, particularly in Guntur: men were much more likely than women to perceive that their wives would become suspicious if they used condoms (34% of men compared to 11% of women in Guntur and 10% and 5%, respectively in Dhar and Guna).

Perceptions of self-risk

Related to lack of awareness of sexual and reproductive health matters are married young people's low perceptions of personal risk of STI/HIV and other adverse reproductive health outcomes. To assess respondents' perceptions of personal risk, two questions were posed: all those who were aware of STI/HIV were asked whether they perceived themselves to be at risk of acquiring STI/HIV; and all those who reported that they/their wives had experienced complications during pregnancy, delivery or the postpartum period relating to the first birth were asked whether they perceived these complications to be serious/life-threatening.

Findings show that perceptions of personal risk of acquiring HIV/STIs were generally low in both settings (Table 5.3). However, there were notable setting-specific and gender differences. Surprisingly, young women and men in Guntur were less likely to perceive themselves to

Table 5.3:

Perceptions of self-risk

Of those who were aware of STIs or HIV, % who:	Guntur		Dhar & Guna	
	Women (N=1,343)	Men (N=1,056)	Women (N=819)	Men (N=896)
Perceive themselves to be at risk of acquiring STI/HIV				
Definitely	3.4	1.7	14.8	6.1
Can't say	2.1	0.9	16.1	10.8
Of those who reported risky behaviours and situations,[1] % who:	**Women (N=175)**	**Men (N=382)**	**Women (N=90)**	**Men (N=349)**
Perceive themselves to be at risk of acquiring STI/HIV				
Definitely	17.7	3.9	34.4	10.3
Can't say	4.6	1.8	14.4	10.6
Of those who/whose wives had at least one live or still birth and experienced pregnancy-related complications,[2] % who:	**Women (N=229)**	**Men (N=135)**	**Women (N=634)**	**Men (N=251)**
Perceived their/their wives pregnancy-related complications as serious or life threatening	89.5	83.0	54.3	64.5

Note:[1] Includes those who reported any unprotected premarital or extra-marital sexual experiences or who suspected that their spouses might be having an extra-marital affair or suffering from an STI but had never used a condom in marital sex.
[2]Includes the following complications during pregnancy, delivery or the postpartum period: high blood pressure or blurred vision, swelling of hands, legs or face, high fever, heavy bleeding and prolonged labour.

be at risk than were their counterparts in Dhar and Guna. Moreover, within each setting, young women were more likely than young men to report that they were at risk. For example, just 3 percent of young women and 2 percent of young men in Guntur perceived themselves to be definitely at risk compared to 15 percent and 6 percent, respectively, in Dhar and Guna. Even among those who reported risky behaviours and situations, setting-specific differences were notable. Only 18 percent of women and 4 percent of men in Guntur compared to 34 percent of and 10 percent, respectively, in Dhar and Guna clearly perceived that they were at risk. These findings indicate a considerable disconnect between perceptions of risk and reports of risky behaviours and situations. However, while it is not clear from the data why this gap was smaller in Dhar and Guna than in Guntur, the possibility of some underreporting of self-risk in Guntur, the high HIV prevalence setting, cannot be ruled out.

Significant setting-specific differences were evident with regard to perceptions of risk of maternal morbidity and mortality. The vast majority of young women (90%) and men (83%) in Guntur who reported that they/their wives had experienced one or more severe symptoms of pregnancy-related complications, including high blood pressure, high fever, haemorrhage and prolonged labour, acknowledged that the complication was serious or life-threatening. In contrast, in Dhar and Guna, corresponding percentages were much lower—54 percent among young women and 65 percent among young men—indicating that even though complications were recognised, the seriousness of such complications was less likely to be acknowledged in Dhar and Guna.

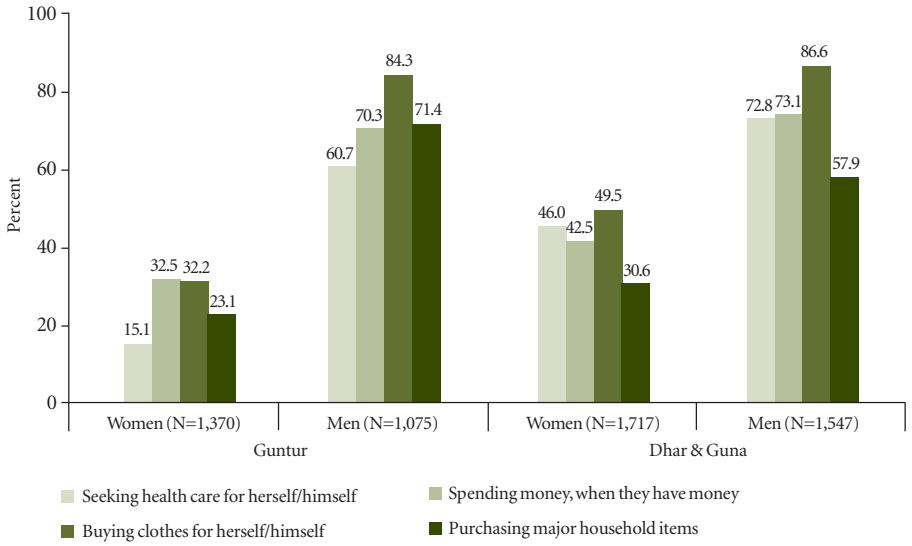
Agency and gendered norms and experiences

Unequal gender norms and power imbalances exacerbate the sexual and reproductive health vulnerability of married young women and men, though in different ways. In this study, a number of measures were used to assess the agency of married young women and men, including their role in decision-making, their mobility and access to resources. The extent to which young people's attitudes and experiences reflected gender double standards were assessed by measures of gender role attitudes, inter-spousal violence and power dynamics in marital relationships.

Role in decision-making

Four indicators were used to assess respondents' role in decision-making related to family finances and health. Respondents were asked whether they were involved in decisions relating to seeking health care for themselves; spending money; buying clothes for themselves; and purchasing major household items (Figure 5.7). Three findings emerge. First, as expected, significant gender differences were evident in both settings; irrespective of the item, young women were significantly less likely than young men to report a role in decision-making. Gender differences were wider in Guntur than in Dhar and Guna. For example, in Guntur, only 15 percent of young women compared to 61 percent of young men reported having a say in decisions regarding their own health care; in contrast, in Dhar and Guna, 46 percent of young women compared to 73 percent of young men reported having a say in such decisions. Second, differences were also evident by setting: by and large, respondents from Guntur were less likely than their counterparts in Dhar and Guna to report being involved in making these decisions. Third, of note is the finding that substantial proportions of young men reported not being involved in decision-making in both settings; in these age-stratified settings, it is likely that senior family members made decisions independently of even young men.

Figure 5.7:
Role in decisions related to family finances and health



Mobility

Questions on mobility were posed only to female respondents; young women were asked whether they were allowed to visit a number of places unescorted including a friend/ relative within and outside the village, respectively, a nearby village for entertainment and a health facility. Findings presented in Figure 5.8 suggest that young women in both settings had limited mobility: no more than 30 percent of women by and large reported that they could visit most places unescorted. However, differences were evident by setting. Notably, young women in Guntur were freer to visit various places unescorted than were those from Dhar and Guna; for example, 77 percent of women in Guntur reported that they could visit a friend or relative unescorted within the village compared to 31 percent from Dhar and Guna. These setting-specific differences perhaps reflect the fact that because of the practice of village endogamy in Andhra Pradesh (Karve, 1965), young women in Guntur were more likely than those in Dhar and Guna to be married within or close to their natal homes.

Access to resources

Young people's access to resources was assessed through responses to two questions: whether respondents had some savings, and whether they had a bank or post office account. Study findings show that in both settings, young women and men reported limited access to resources, but we note that the implications of access to resources are different for young women and men (Figure 5.9). No more than 14 percent of young women or men in either setting reported that they had some savings. Similarly, fewer than 20 percent of respondents reported that they had a bank account or post office account; indeed, the proportion of young women who reported having an account was almost negligible (just 1%) in Dhar and Guna.

Figure 5.8:

Freedom to visit unescorted different locations within and outside the village

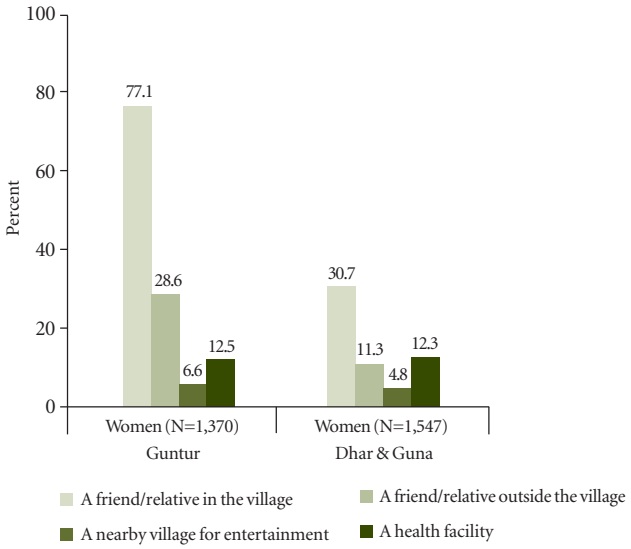
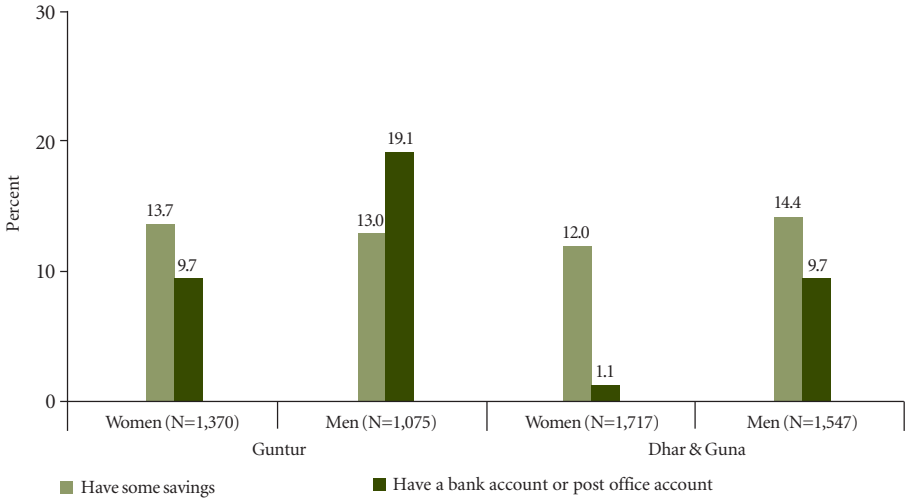


Figure 5.9:

Access to resources



Gender role attitudes

To assess respondents' attitudes towards gender roles, study participants were asked whether they agreed or disagreed with a number of statements regarding women's autonomy and men's involvement in household matters. Findings presented in Figure 5.10 show that young women were, by and large, more likely to report egalitarian attitudes on most items than were young men in both settings. However, responses varied by topic. The statement that was most likely to generate a gender egalitarian response among young men and women in both settings was whether educating boys was more important than educating girls, with between 54 percent and 84 percent of respondents disagreeing that boys' education should be given priority. Correspondingly, the statement that was most likely to elicit a gender inegalitarian response was whether a woman should obtain her husband's permission for most things, with 79–91 percent of respondents agreeing with the statement.

Inter-spousal violence

Questions used in demographic health surveys were used to assess the extent of emotional[2] and physical violence within marriage. Findings presented in Figure 5.11 indicate substantial levels of emotional and physical violence against women within marriage in both settings; however, the prevalence of such violence was more common in Dhar and Guna than in Guntur. For example, 11 percent of young women in Guntur compared to 18 percent in Dhar and Guna reported that they had ever experienced emotional violence perpetrated by their husbands. Similarly, 34 percent of young women in Guntur compared to 41 percent in Dhar and Guna reported having ever experienced physical violence perpetrated by their spouses. The majority of these women (86%) also reported experiencing some form of physical violence in the year preceding the survey.

[2]*To assess the prevalence of emotional violence, all respondents were asked: "Did your spouse ever do something to humiliate you in front of others or threaten to hurt or harm someone close to you?"*

Figure 5.10:

Gender role attitudes

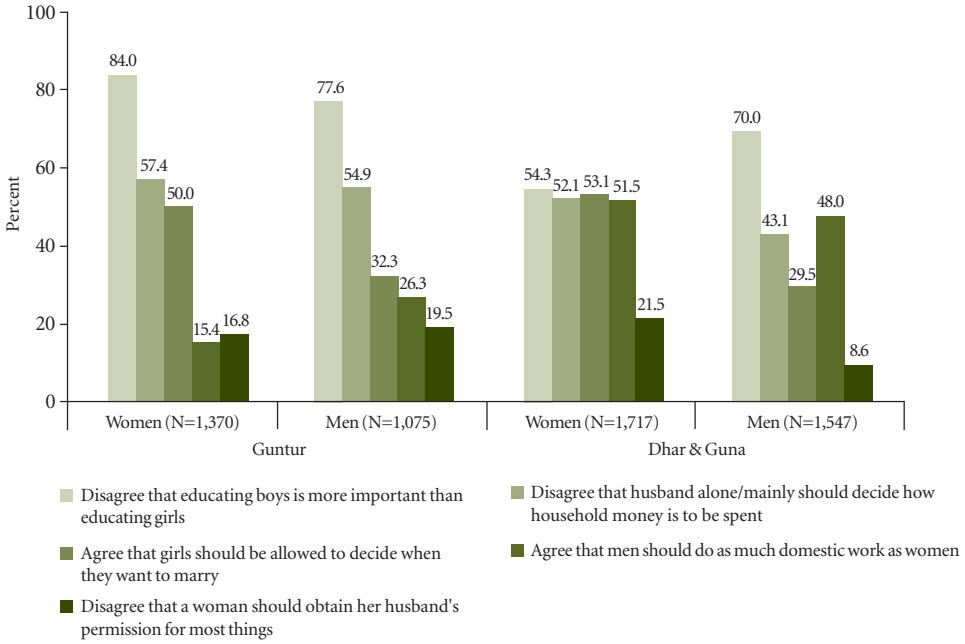
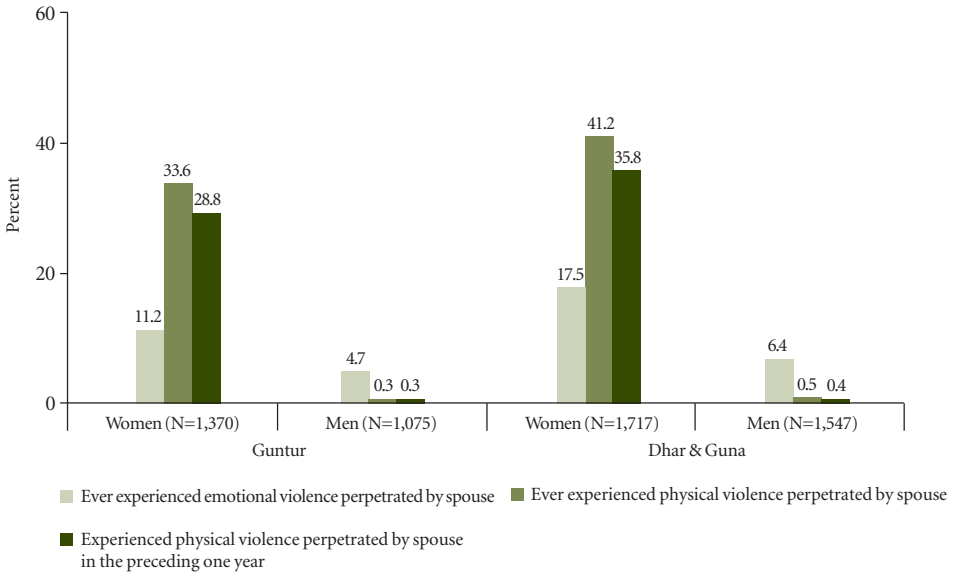


Figure 5.11:

Experience of spousal violence



As expected, few young men reported having experienced physical or emotional violence perpetrated by their wives—fewer than 1 percent of young men reported having ever experienced physical violence and 5–6 percent reported having experienced emotional violence in both settings.

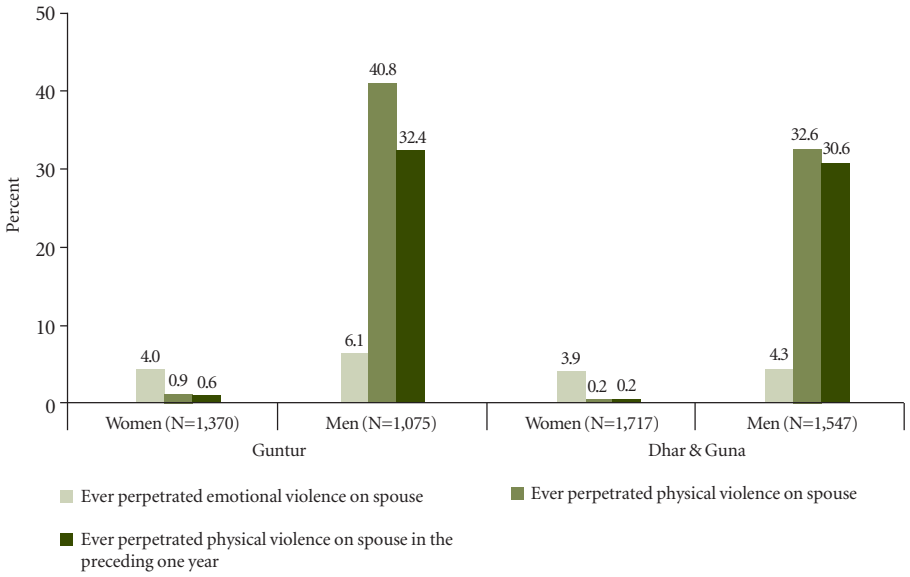
With regard to the perpetration of spousal violence, while only 4–6 percent of young men reported ever perpetrating emotional violence on their wives in either setting, as many as 41 percent of young men in Guntur and 33 percent in Dhar and Guna reported ever perpetrating physical violence on their wives (Figure 5.12). Moreover, about one-third of young men in both settings reported perpetrating physical violence on their spouses in the one year preceding the survey. As expected, few young women reported that they had perpetrated emotional or physical violence on their husbands—4 percent reported perpetrating emotional violence and less than 1 percent reported perpetrating physical violence. This contrasts with the relatively higher percentages of young women who reported (see Figure 2.2) that they had experienced sexual violence and young men who reported that they had perpetrated it on their wives (for example, 44% and 10% of young women and men in Guntur and 56% and 36%, respectively, in Dhar and Guna).

Power dynamics in marital relationships

In addition to questions on inter-spousal violence, the study also enquired about power dynamics in marital relationships, measured by responses to seven questions (listed in Table 5.4) relating to controlling behaviours by husbands. These included questions on whether the husband typically controlled his wife's movement, interaction or access to resources;

Figure 5.12:

Perpetration of spousal violence



whether the husband had ever accused his wife of being unfaithful; and whether he would be angry if his wife did not get food ready on time or if she talked to other men. Female respondents reported on their experiences of controlling behaviours by their husbands and male respondents reported on exercising such control over their wives.

Findings presented in Table 5.4 indicate significant setting-specific differences; young women and men in Dhar and Guna were far more likely to report controlling behaviours by their husbands than their counterparts in Guntur. While 90 percent and 85 percent of young women and men in Dhar and Guna reported experiencing/perpetrating at least one controlling behaviour, somewhat fewer—58 percent and 62 percent, respectively—reported so in Guntur.

Couple communication

Couple communication was measured by responses to three general questions: whether or not the respondent and spouse had discussed money, love and sexual matters; and to three questions relating to sexual and reproductive health: whether or not the respondent and spouse had discussed contraception to delay the first pregnancy, using a method to prevent infection and seeking antenatal care during the first pregnancy. Findings presented in Table 5.5 show that couple communication on general topics was common in both settings. Also, while gender differences were not marked in Guntur, such differences were significant in Dhar and Guna, with men consistently more likely to report communication on most topics than women.

Table 5.4:

Power dynamics in marital relationships

Characteristic (%)	Guntur		Dhar & Guna	
	Women (N=1,370)*	Men (N=1,074)*	Women (N=1,608)*	Men (N=1,446)*
Husband will get angry if wife does not get food ready on time	30.4	47.9	55.8	52.8
Husband will get angry if wife talks to other men	16.9	9.5	44.5	54.9
Husband had accused wife of being unfaithful	4.5	1.9	9.1	4.6
Husband usually does not permit wife to meet her female friends	6.1	5.5	35.1	24.0
Husband usually tries to limit wife's contact with her family	33.8	12.5	28.4	21.9
Husband does not trust wife with money	2.7	2.2	22.7	7.1
Husband usually insists on knowing where wife is	7.4	12.1	21.6	44.9
At least one of the above controlling behaviours	*58.0*	*61.6*	*89.6*	*85.2*

Note: Of those who had begun cohabiting.*

Table 5.5:

Couple communication on general topics and sexual and reproductive health matters

Topic (%)	Guntur		Dhar & Guna	
	Women (N=1,370)*	Men (N=1,074)*	Women (N=1,608)*	Men (N=1,446)*
How to spend money	80.1	84.4	58.2	74.4
Love	83.3	74.7	71.3	87.7
Sexual matters	77.7	76.5	59.6	80.4
Using a contraceptive method to delay the first pregnancy	5.3	8.8	16.5	28.1
Using a method to prevent an STI	2.0	2.7	4.9	7.6
Seeking antenatal care during the first pregnancy**	88.7	80.1	50.1	37.0

*Note:*Of those who had begun cohabiting.*
***Among those who had at least one live or still birth.*

As can be seen from Table 5.5, the extent of couple communication on sexual and reproductive health matters varied by topic and setting. The topic most likely to have been discussed was the need to seek antenatal care; even so, considerably more young women and men from Guntur reported communicating on this topic (over 80%) than in Dhar and Guna (50% and 37% of young women and men, respectively). Contraception was discussed by many fewer in both settings; and the proportion who discussed this topic differed by setting. Fewer than 10 percent of young women or men in Guntur discussed whether or not to use contraceptives in order to delay the first pregnancy, compared to 17 percent of young women and 28 percent of young men in Dhar and Guna. Spousal communication was least likely to be reported on the topic of using a contraceptive method to prevent an STI in both settings (only 2–3% in Guntur and 5–8% in Dhar and Guna).

Familial and non-familial support

Married young people's ability to adopt protective actions to reduce their vulnerability to adverse sexual and reproductive health outcomes is also influenced by the extent and nature of family and social support available. Family and peer support were measured by responses to a series of questions regarding the person with whom young women and men were most likely to confer with on such issues as taking a job, problems relating to menstruation (females) and nocturnal emission (males), genital discharge and relationship with husband (females).

Significant gender differences were evident in both settings. Young women in Guntur and Dhar and Guna were more likely to report a family member than a non-family member as the person with whom they would discuss these topics—66–98 percent reported a family member in Guntur and 88–98 percent reported so in Dhar and Guna (Table 5.6). Only 3 percent of young women in both settings reported conferring

Table 5.6:

Extent of familial and non-familial support

% reporting:	Guntur		Dhar & Guna	
	Women (N=1,370)	Men (N=1,075)	Women (N=1,717)	Men (N=1,547)
A family member as a confidante for discussing:				
Taking a job	97.8	76.4	97.9	66.9
Problems relating to menstruation/nocturnal emission	91.8	10.3	94.2	22.4
Problems relating to vaginal/urethral discharge	90.4	8.8	93.8	21.0
Relationship with husband	66.0	N/A	88.3	N/A
A non-family member as a confidante for discussing:				
Taking a job	0.9	14.5	1.3	15.8
Problems relating to menstruation/nocturnal emission	2.3	74.0	2.7	61.9
Problems relating to vaginal/urethral discharge	2.5	79.9	3.1	68.4
Relationship with husband	3.0	N/A	3.1	N/A
Friends and membership in groups				
Friend in marital village	43.5	N/A	42.6	N/A
Member of a group/s	25.6	5.0	1.5	15.3

Note: N/A: Question not asked.

with a non-family member on these issues, indicating limited non-familial support among young women. In contrast, young men reported that the person with whom they were most likely to discuss various topics differed by topic. For example, they were more likely to confer with a family member than a non-family member on a general topic such as taking a job, but were more likely to discuss health issues such as nocturnal emission or urethral discharge with a non-family member than a member of the family.

While the majority of respondents reported some family or non-family support, depending on the topic, a significant minority in both settings reported that they would not discuss these issues with anyone. For example, among young women, 6–31 percent in Guntur and 3–9 percent in Dhar and Guna reported that they would not discuss these issues with anyone; similarly, among young men 9–16 percent and 11–17 percent, respectively, reported so (not shown in tabular form).

To assess the extent of young people's social support network, the study also enquired about whether young women had friends in their marital village, and whether young women and men were members of groups. In both settings, only some two-fifths of young women reported that they had friends in their marital village. Likewise, few young women and men reported membership in a group; however, young women in Guntur were considerably more likely than young men to belong to a group (26% versus 5%); the reverse was evident in Dhar and Guna (2% versus 15%).

Access to information and services on sexual and reproductive health

Access to information and services is an important factor influencing young people's sexual and reproductive health vulnerability. Respondents were asked how regularly they accessed the mass media on the one hand, and the extent to which they had been exposed to messages on sexual and reproductive health matters through the mass media or information materials in the three months preceding the survey on the other. To assess young people's access to sexual and reproductive health services, respondents were also asked whether health care providers had interacted with them and discussed matters relating to sexual and reproductive health in the three months preceding the survey. Finally, respondents were asked about the quality of care that they received when they had sought sexual and reproductive health services.

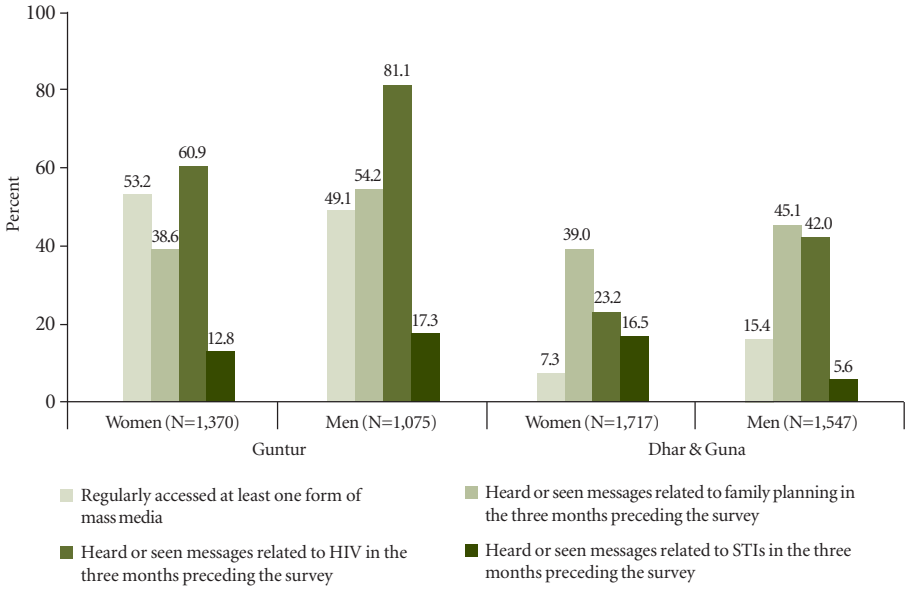
Access to mass media and information materials

Findings presented in Figure 5.13 show that regular exposure to the mass media was more common in Guntur than in Dhar and Guna. One-half of young women and men in Guntur compared to just 7 percent of young women and 15 percent of young men in Dhar and Guna reported that they watched television, read newspapers, accessed the internet or saw films regularly.

All respondents, irrespective of whether or not they were exposed regularly to the mass media, were asked whether they had been exposed recently to messages related to family planning, HIV and STIs other than HIV either through the mass media or information materials. Findings show that the extent of exposure varied by setting and topic. Not surprisingly, of the three topics, the largest proportion of young women and men from Guntur

Figure 5.13:

Access to information on sexual and reproductive health matters



(61% and 81%, respectively) reported having heard or seen messages related to HIV in the three months preceding the survey. In contrast, in Dhar and Guna, the largest proportion reported having been recently exposed to information on family planning; even so, only 39 percent of young women and 45 percent of young men had heard or seen such messages, proportions not very different from those reported by respondents in Guntur. In both settings, young women and men were least likely to have been exposed to messages related to STIs other than HIV in the recent past—no more than 17 percent in Guntur or Dhar and Guna.

Health care providers' interaction with young people

The extent to which health care providers interacted with young people was measured by a number of indicators, including whether respondents had been counselled on such topics as family planning, HIV and other STIs by a provider in the three months preceding the survey; whether a provider had discussed with them the option of using contraceptives to delay the first pregnancy or using a condom for dual protection; and, finally, whether a provider had discussed with them pregnancy-related care during the first pregnancy.

Findings reported in Table 5.7 show that few young people—less than one-third—reported interaction on any topic with a health care provider in the recent past. Topics discussed varied by setting. In Guntur, the largest proportion reported that a health care provider had counselled them on HIV; even so, proportions were low (16% of young women and 30% of young men). In Dhar and Guna, the topic most likely to have been discussed was family planning; however, only 12 percent of young women and 10 percent of young men reported that a health care provider had discussed this topic with them in the three months preceding the survey. In both settings, far fewer (5% or less) reported that a health care provider had discussed STIs other than HIV with them.

Few young women and men in both settings (1–2% in Guntur and 9% in Dhar and Guna) reported that a health worker had discussed with them the option of using a contraceptive method to delay the first pregnancy. Likewise, just 3 percent of respondents in both settings had received information from a health care provider about using condoms for dual protection.

Considerably, more interaction was reported with health care providers on topics related to maternal health at the time of young women's first pregnancies; however, respondents from Guntur were far more likely to report interaction than were those from Dhar and Guna. The extent of interaction also varied depending on the subject. For example, the largest proportion of young women and men in both settings (99% and 89%, respectively, in Guntur, and 50% and 45%, respectively, in Dhar and Guna) reported having received information on antenatal care from a health worker. In contrast, young women and men were least likely to have reported that a health worker discussed with them issues relating to postpartum care (17% and 53%, respectively, in Guntur, and 10% and 9%, respectively, in Dhar and Guna). It is notable that in Guntur, young men were more likely than young women to report that a health care provider had discussed with them issues related to danger signals, preparation for delivery and the importance of postpartum check-ups, whereas it was young women who were more likely to report

Table 5.7:

Interaction with health care providers

% reporting a health care provider discussed the following in the last three months:	Guntur		Dhar & Guna	
	Women (N=1,370)	Men (N=1,075)	Women (N=1,717)	Men (N=1,547)
HIV-related issues	16.0	29.7	7.0	8.3
Using a contraceptive method to delay pregnancy	9.4	11.5	11.9	10.1
STIs other than HIV	5.3	4.4	5.3	1.6
Of those who have cohabited, % reporting a health care provider ever discussed the following:	**Women (N=1,370)**	**Men (N=1,074)**	**Women (N=1,608)**	**Men (N=1,446)**
Using a contraceptive method to delay the first pregnancy	1.0	2.4	9.3	9.1
Using a condom to prevent pregnancy and STIs	3.1	3.5	2.9	2.8
Of those who/whose wives had at least one live or still birth, % reporting a health care provider ever discussed the following:	**Women (N=1,014)**	**Men (N=759)**	**Women (N=1,225)**	**Men (N=1,065)**
Care during pregnancy	98.5	89.2	49.6	44.8
Danger signs during pregnancy, childbirth and the postpartum period	55.4	56.1	18.1	18.4
Preparation for delivery	29.2	56.1	12.0	9.7
Postpartum check-ups	16.5	53.1	9.9	9.4

interaction on antenatal care. It is possible that fewer young women than young men had received information from a health care provider on issues related to delivery and postpartum care because of the custom of young women going to their natal home for their first delivery, and the consequent limited opportunity for a provider to discuss these issues with young women. In Dhar and Guna, while fewer young people interacted with a health worker, both young women and young men were equally likely to be contacted on all issues.

Quality of care

Young women and men who had sought services/had accompanied their wives to seek services for pregnancy-related care, or sought treatment for genital tract illness and HIV testing were asked about their perceptions of the quality of care received. Findings are presented in Table 5.8.

All female respondents who visited a facility for an antenatal check-up, delivery, postpartum check-up or treatment of pregnancy-related complications, and all male respondents who reported that they accompanied their wives to a facility at least once during the first pregnancy/birth were asked questions on the quality of pregnancy-related care received. Female and male respondents were asked different sets of questions. While both female and male respondents were asked whether the provider had treated them with respect, female respondents were

Table 5.8:

Quality of care received

Of those who sought pregnancy-related health services/ accompanied their wives to a facility for pregnancy-related services* % reporting that:	Guntur		Dhar & Guna	
	Women (N=998)	Men (N=505)	Women (N=877)	Men (N=312)
They were treated with respect	99.0	62.6	81.1	52.2
They felt embarrassed that others could hear or see their interaction with the provider	7.1	N/A	32.4	N/A
Husband accompanied wife to the consultation room	N/A	63.4	N/A	55.1
Provider encouraged husband to participate in the consultation	N/A	57.6	N/A	47.8
Of those who sought treatment for symptoms of reproductive tract illness, % reporting that:	**Women (N=30)**	**Men (N=18)[1]**	**Women (N=113)**	**Men (N=42)**
They were advised about the need for partner check-up	26.7	(4)	31.0	35.7
They were advised to use condoms	10.0	(3)	21.2	14.3
They were recommended a laboratory test	36.7	(8)	23.0	35.7
They were treated with respect	90.0	(16)	70.8	83.3
They felt embarrassed that others could hear or see their interaction with the provider	30.0	(9)	24.8	23.8
Of those who underwent HIV testing, % reporting that:	**Women (N=675)**	**Men (N=179)**	**Women (N=5)[1]**	**Men (N=16)[1]**
They received counselling on how to protect themselves or their partners from HIV	10.2	19.6	(4)	(5)

*Note:*Among those who/whose wives had at least one still or live birth.*
[1] Figures in brackets are numbers and not percentages.
N/A: Question not asked.

also asked whether they felt they had sufficient privacy, that is, whether they felt embarrassed that people could hear or see their interaction with the provider. Male respondents were also asked whether they had accompanied their wives to the consultation room and whether the provider encouraged them to participate in the consultation.

Findings show that young women in Guntur were more satisfied with the services received than young women in Dhar and Guna. For example, 99 percent of young women in Guntur compared to 81 percent in Dhar and Guna reported that they were treated with respect (Table 5.8). Similarly, concerns about lack of privacy were reported by many more young women in Dhar and Guna than in Guntur (32% versus 7%).

In general, young men who accompanied their wives to a health facility for maternal health services were less likely than women to report that they were treated with respect; even so, those in Guntur were more likely to report that they were treated with respect than were those in Dhar and Guna. Young

men in Guntur were also more likely to report that they had accompanied their wives to the consultation room than their counterparts in Dhar and Guna (63% versus 55%); similarly, they were more likely to report that the provider encouraged them to participate in the consultation, with 58 percent and 48 percent, respectively, reporting so.

Respondents who reported that they had sought care for symptoms of reproductive tract illness were asked about the quality of care received. Questions focused on the kind of services provided, whether they were treated with respect and whether privacy was maintained. However, findings must be interpreted with caution as only a small minority reported having experienced symptoms of reproductive tract illness and having sought treatment. Irrespective of setting, findings show that services provided were far from adequate; few were advised that their partners required a check-up, to use condoms or to undergo laboratory tests. While the vast majority reported that they were treated with respect, concerns about lack of privacy were raised by substantial proportions of young women and men. In terms of quality of care received during HIV testing, findings show that few were counselled about ways of protecting themselves or their partners from HIV.

CHAPTER 6

Summary and recommendations

This chapter summarises the major findings of the study and suggests programme recommendations to address married young people's vulnerability to STI/HIV and other adverse sexual and reproductive health outcomes, including early and unplanned pregnancies and poor maternal health outcomes.

Summary

Findings clearly indicate that married young women and men face significant sexual and reproductive health risks. While this study focused on married youth, some of the evidence, for example on premarital sexual behaviours of young people, indicates that unmarried youth are also at risk. Findings also confirm wide gender differences and, to some extent, setting-specific differences in risk profiles.

This study underscores young men's vulnerability to STI/HIV. First, irrespective of the setting, premarital and extra-marital sexual relationships were fairly common: about one in three young men in Guntur and over one in four young men in Dhar and Guna reported premarital sexual experiences, and one in 10 in both settings reported extra-marital sexual experiences. Second, both premarital and extra-marital sexual experiences were characterised by multiple partnerships; of those young men who reported premarital sexual experiences, one in three or more reported having had sex with more than one sexual partner, and of those who reported extra-marital sexual experiences, one in 10 or more had more than one extra-marital sexual partner. Multiple partnerships among those who reported premarital and extra-marital relationships were somewhat more common in Guntur than in Dhar and Guna. The range of partners with whom young men engaged in sex varied widely across the study settings. For example, while a romantic partner was most likely to be cited by all those who had premarital sexual experiences, young men in Guntur were more likely to have reported sexual experiences with sex workers, older married women or casual partners than their counterparts in Dhar and Guna. Third, sexual relations before, within or outside marriage were largely unprotected. For example, no more than 7 percent of young men who reported premarital sexual experiences and no more than 14 percent of those who had extra-marital sexual relations either in Guntur or in Dhar and Guna reported that they always used condoms with their sexual partners. Similarly, no more than 9 percent of young men reported current condom use in marriage. Even so, while consistent condom use in premarital sexual relationships was slightly more frequently reported by young men in Guntur than in Dhar and Guna, the reverse pattern was apparent with respect to condom use in marital and extra-marital sexual relationships. Indeed, condom use within marriage was virtually non-existent in Guntur. These results corroborate findings from large-scale community-based studies on sexual risk behaviours among young men conducted elsewhere in India (Alexander et al., 2006; IIPS and Population Council, 2007).

Findings on sexual risk behaviours among young women also suggest their vulnerability to STIs/HIV; however, their patterns of risk were different from those of young men. First, as expected,

sexual activity took place overwhelmingly within the context of marriage in both settings. Even so, significant minorities of young women in both settings reported the experience of premarital (about 5%) and extra-marital sex (3–5%). Second, irrespective of setting or whether sexual initiation occurred before or within marriage, most young women initiated sex at a young age, that is, at age 15 or below; sexual initiation by age 15 tended to be somewhat less common in Dhar and Guna, primarily because the practice of *gauna* delayed sexual initiation for many young women in this setting. Third, sexual experiences were coercive for substantial proportions of young women, irrespective of whether sex took place before, within or outside marriage. Indeed, sexual coercion within premarital and extra-marital sexual relationships tended to be somewhat more common in Dhar and Guna than in Guntur (12–18% versus 8–9%). These results concur with findings from studies that have assessed coercive sexual experiences among young women in premarital relationships and marriage (Alexander et al., 2006; George, 2002; Joshi et al., 2001; Khan et al., 1996; Maitra and Schensul, 2004; Santhya et al., 2007; Sharma, Sujay and Sharma, 1998). Finally, women's reporting of condom use—like that of men—in premarital, marital and extra-marital sexual relationships also indicates that condoms were rarely used.

Vulnerability to STI/HIV was clearly exacerbated by inadequate care seeking for symptoms of genital tract infection. For example, while only small proportions (3–29%) reported having experienced symptoms of genital tract infection, no more than one in four young women or men in either setting sought treatment as soon as symptoms were noticed. Likewise, few respondents took action to prevent the transmission of infection to their spouses: no more than 16 percent asked their spouses to get a check-up, and of these no more than 14 percent reported that their spouses had actually sought a check-up. Similarly, few respondents reported that they either abstained from sex or used a condom while having sex when they experienced symptoms of genital tract infection.

Findings on contraceptive behaviours also confirm the vulnerability of married young women to such adverse reproductive outcomes as early and unplanned pregnancies. The practice of contraception was far from universal in both settings: only 34–39 percent of young women and men in Guntur and 14–19 percent in Dhar and Guna reported using a contraceptive method at the time of the survey. These results are similar to the rates calculated for currently married young women and men in Andhra Pradesh and Madhya Pradesh using data from NFHS-3. Even among the small proportion who desired to delay the first pregnancy, few (3% in Guntur and 2–17% in Dhar and Guna) succeeded in using a non-terminal contraceptive method to do so. Indeed, the use of a non-terminal method was relatively rare; the majority of those who used a contraceptive method reported that female sterilisation was the method first used—similar results are observed in NFHS-3 and other studies in India (Alexander et al., 2006; IIPS and Macro International, 2007a; Ram et al., 2006). Not surprisingly, sizeable proportions of young women became mothers at a young age. Two in five young women in Guntur and one in three in Dhar and Guna had their first birth by age 18. Findings also highlight substantial unplanned pregnancies in both settings, particularly in Dhar and Guna. For example, one-fifth of young women in Guntur and almost two-fifths in Dhar and Guna reported that their most recent pregnancy was unplanned.

Young women were also vulnerable to poor pregnancy-related experiences and poor maternal health outcomes. Comprehensive pregnancy-related care was reported by about half of all respondents in Guntur compared to less than one-fifth in Dhar and Guna; skilled attendance at delivery was not universal, with about one in seven women in Guntur and about half in Dhar and Guna reporting delivery by an unskilled person. Similarly, treatment seeking for pregnancy-related complications was limited. While the situation with respect to the practice of antenatal check-ups, institutional delivery and treatment seeking for pregnancy-related complications was far better in Guntur than in Dhar and Guna, accessing postpartum services for young mothers was found to be limited in both settings.

The study explored several background factors that might influence married young people's ability to adopt protective behaviours and practices to reduce STI/HIV risk and, at the same time, make pregnancy safer and address their unmet need for contraception. These factors included awareness of sexual and reproductive health matters, attitudes towards protective actions, perceptions of personal risk, autonomy and gendered norms, couple communication, family and social support, and access to sexual and reproductive health information and services.

As observed in various studies in India (Alexander et al., 2006; George, 2002; George and Jaswal, 1995; IIPS and Population Council, 2007; Jejeebhoy, 2000; Jejeebhoy and Sebastian, 2004; Khan et al., 1996; NACO and UNICEF, 2002), findings of this study also underscore the fact that young people's awareness of most sexual and reproductive health matters was limited. For example, no more than 43 percent of young women or men in either setting were aware that a woman can get pregnant the first time she has sexual intercourse. Similarly, while awareness of the importance of regular antenatal check-ups was widespread, the importance of postpartum check-ups was not as widely known. Likewise, few had heard of STIs other than HIV even in such high HIV prevalence settings as Guntur. Even on such topics as contraceptive methods about which young people were generally aware, findings show that knowledge of specific contraceptive methods that are suitable for young people was far from universal; moreover, in-depth understanding of various methods was limited in both settings. By and large, gender and setting-specific differences were evident: apart from topics related to pregnancy-related care, young men appeared to be better informed than women about most sexual and reproductive health matters; and respondents from Guntur were generally better informed than were those from Dhar and Guna.

Attitudes towards protective actions varied. By and large, young people—irrespective of gender and setting—appeared to support premarital HIV testing; even so, young people in Guntur were more supportive of such testing than were those from Dhar and Guna. In contrast, attitudes towards condom use within marriage reflected young people's association of condoms with unfaithfulness, sex work and so on, and tended to be more unfavourable in Guntur than in Dhar and Guna. For example, of those who were aware of condoms, about one-half of young women and two-fifths of young men in Guntur reported that condoms are only for relations with sex workers and unfaithful persons, compared to just 10 percent of young women and 16 percent of young men in Dhar and Guna. Similarly, one-third of young women and almost one-half of young men in Guntur reported that their husbands or they would get angry if the

wife asked the husband to use a condom. Similar views towards condom use were expressed by young men in a study conducted in Maharashtra (Verma et al., 2006).

As observed in studies elsewhere (Chatterjee and Hosain, 2006; Kanniappan, Jeyapaul and Kalyanwala, 2007; Narayan et al., 2000), perceptions of personal risk of acquiring HIV/STIs were generally low in both settings, particularly in Guntur. Risk perceptions were low even among those who reported such risky behaviours as non-use of condoms or multiple partner relations.

Unequal gender norms and power imbalances appeared to characterise the sexual relationships of the majority of respondents in both settings both within and outside marriage, underscoring young women's vulnerability and inability to negotiate safe practices with their husbands as well as with their premarital and extra-marital partners. Findings, corroborated by results from other studies (Barua and Kurz, 2001; Kulkarni, 2003; Santhya and Jejeebhoy, 2003), suggest that married young women, by and large, played a limited role in decision-making, had little freedom of movement and limited access to resources. Additionally, they were subjected to both emotional and physical violence and controlling behaviours by their husbands.

Limited couple communication further undermined married young people's ability to adopt protective actions in these settings. While large proportions of couples did indeed communicate on general and non-sensitive topics, many fewer reported that they discussed sexual and reproductive health matters. Communication varied considerably by topic—the topic most likely to be discussed was antenatal care, and contraception to delay pregnancy or prevent STIs was the least likely to be discussed.

Large proportions of respondents reported access to support from the family, including their spouses, or social support. By and large, young women from both settings tended to report a family member as a confidante on both general and sexual and reproductive health matters. Young men, whose social networks were wider, were more likely to confide sensitive sexual matters to non-family members. While the majority did report access to some form of family or peer support, a significant minority (3–31%) reported that they would not discuss sensitive sexual matters with anyone.

Access to information related to sexual and reproductive health was, by and large, limited and varied by setting and topic. In Guntur, while 61–81 percent of young people had heard or seen messages related to HIV in the three months preceding the survey, only 39–54 percent were exposed to messages related to family planning. In contrast, in Dhar and Guna, many fewer (23–42%) had heard or seen messages related to HIV or family planning. Irrespective of the setting, young people were least likely to have been exposed to messages related to STIs other than HIV in the recent past.

Findings highlight that young people's interaction with a health care provider on sexual and reproductive health topics was limited. Few young women and men in both settings (1–9%) reported that a health worker had discussed with them the option of using a contraceptive method to delay the first pregnancy or using a condom for dual protection. However, considerably larger proportions noted that a health care provider had discussed with them issues related to maternal health at the time of their first pregnancy; even so, pregnancy-related interaction was far more likely to be reported by

respondents from Guntur than Dhar and Guna. These findings suggest that public sector health programmes continue to reach married youth only after they have made the transition to parenthood, and that these programmes have yet to take significant strides in making comprehensive sexual and reproductive health information and services available to all groups of adolescents and young people as proposed in the RCH Programme II. At the same time, findings that substantial proportions (53–89%) of young men in Guntur received information on pregnancy-related care from health care providers indicate a positive attitudinal change in providers to also focus on men with regard to issues related to pregnancy care.

While not all respondents had accessed care, satisfaction with the quality of care received at health facilities varied by service and setting. Those who received pregnancy-related services, notably young women in Guntur, reported satisfaction with the quality of care received; young men in Guntur were also more likely than young men in Dhar and Guna to report that they were treated with respect and that they were encouraged by the provider to participate in pregnancy-related consultations. However, with regard to quality of care received for treatment of genital tract infection or for an HIV test, findings show that irrespective of setting, services provided were far from adequate. While these findings on satisfaction with quality of care received are, by and large, encouraging, we note that the possibility of respondents providing courteous responses to questions relating to quality of provider interaction cannot be ruled out.

In short, study findings underscore the vulnerability of married youth to infection, and married young women to early and unplanned pregnancies and pregnancy-related complications. Correspondingly, the behaviours and practices assumed to enhance safe sexual and reproductive health—in-depth awareness of sexual and reproductive health matters, favourable attitudes towards protective actions, ability to recognise personal risk of infection, women's autonomy and adherence to egalitarian gender norms, spousal communication on sexual and reproductive health matters and access to appropriate sexual and reproductive health information and services—were inconsistent and far from universally reported in the study settings.

Recommendations

Study findings clearly suggest that married youth are a distinct group that experiences a wide range of risky behaviours, and faces a number of obstacles that limit their ability to exercise informed choice in the area of sexual and reproductive health. Findings reiterate the need for programmatic attention to address the special needs and vulnerability of married young women and men, and suggest several priority programmatic areas for action:

Build in-depth awareness among the married, the about-to-be-married and the unmarried

Findings that substantial proportions of young people had engaged in sexual risk taking before and within marriage, that few perceived themselves to be at risk of infection despite having engaged in risky behaviours, and that many lacked an in-depth understanding of infection prevention and treatment highlight the need for multi-pronged programmatic efforts targeted at married young people, as well as those about-to-be-married and the unmarried. These efforts should include the provision of detailed information on sexual and reproductive health matters, which should be tailored not only to raise awareness but also to enable young people to correctly assess their own and their partners' sexual risk and to adopt appropriate protective actions.

Reposition the condom as an acceptable contraceptive method for married young people

Findings that condoms were rarely used within marriage, that many young people associated the use of condoms with sex worker relations and unfaithfulness, that few were aware that condoms offer dual protection, that many harboured unfavourable attitudes towards condom use and that health care providers themselves rarely provided married young women and men with condom-related information or counselling clearly underline the pitfalls in current efforts to promote the condom. Clearly, efforts are needed to reposition the condom so that it is recognised as a safe and effective method for use within marriage—especially for young people—and the stigma currently associated with its use among married young women and men is dispelled. In view of the fact that most married young women and men who were practising contraception had adopted female sterilisation, it is important to convey the benefits of condom use even among the sterilised who are unlikely to recognise the need for dual protection. Such efforts are urgently required, particularly in Guntur where young people's attitudes toward condom use were particularly unfavourable and the large majority of those practising contraception were sterilised.

Make efforts to prevent sexual coercion of young women

Findings regarding the pervasiveness of sexual coercion in premarital, marital and extra-marital sex clearly indicate that sexual and reproductive health programmes need to address the issue of coercion within sexual relationships. Whether it is their goal to assist women in protecting themselves from HIV infection or to provide women with contraception, these programmes must take into consideration the fact that a significant proportion of their clients engage in sexual relations against their will, and that messages that advocate faithfulness and condom use are irrelevant where sexual relations are non-consensual. Education and counselling services must address the issue of women's rights, and programme efforts are needed that focus on changing men's attitude of entitlement to engage in sexual relations with their partners/wives without their consent, and norms that condone violence against women more generally.

Support newly-weds who would like to postpone the first pregnancy

Findings show that the social pressure to bear children as soon as possible following marriage persists. Findings from the study reveal that contraceptives were rarely used by even those young women and men who wanted to postpone the first pregnancy; as a result, substantial proportions of women became mothers at a young age. These findings underscore the need for programmatic efforts to support young people, in particular, newly-weds, to postpone the first pregnancy, to build awareness of the adverse effects of early pregnancy and to make it acceptable for young couples to adopt contraception prior to the first birth. At the same time, there is a need to change community and family attitudes to favour postponement of pregnancy and not link a young woman's security within the marital family with her childbearing ability. Moreover, it is clear that health care providers do not reach married young women and men—particularly those who have not yet experienced pregnancy—with information regarding contraception and supplies, thereby contributing to the significant proportions reporting unplanned pregnancies. Such findings clearly indicate the need to reorient programmes to focus on married young people's special need for spacing pregnancies, particularly in Dhar and Guna.

Promote care during delivery and the postpartum period, as well as during pregnancy

Findings underscore that access to maternal health services was far from universal, even at the time of the first—and often the most risky—pregnancy. Few women, particularly in Dhar and Guna, had accessed care during the antenatal, delivery and postpartum periods. These findings highlight that reproductive and child health programmes in the study settings need to lay emphasis on increasing the demand as well as improving the availability of such services. Findings also show that even in Guntur, where antenatal and delivery services were widely utilised, postpartum check-ups were rarely accessed, despite the fact that significant proportions were aware of the importance of these check-ups. Special efforts by health care providers to reach young mothers in the immediate postpartum period are warranted.

Make efforts to reverse traditional notions of masculinity and femininity

Findings reaffirm the underlying role of gender double standards and power imbalances that limit the exercise of informed choice among young couples in numerous ways. For example, traditional norms inhibit young couples from communicating on sensitive matters; affect attitudes to condom use and condom-related negotiation; put pressure on young women to become mothers as soon as possible after marriage so as to ensure their security in their marital home; and promote among young men—and even among young women—a sense of male entitlement to engage in sex with wives or partners in some cases without their consent. Programmes need to promote actions that empower young people, particularly young women, and, at the same time, promote messages that build egalitarian relations between women and men.

Reorient service provision to address the unique needs of married young women and men

Findings have shown that interaction between married young people and health care providers varied widely by topic and setting. For example, although interaction with health care providers on issues relating to antenatal care was most likely to have been reported, even so, fewer than half of all respondents in Dhar and Guna had actually done so. In contrast, many fewer respondents in both settings reported that a health care provider had provided them information or counselled them on other sexual and reproductive health matters. Service utilisation, as described above, was also limited. In short, efforts by health care providers to reach married young people were limited and not commensurate with the extent to which this group is at risk of adverse sexual and reproductive health outcomes, as observed in this and other studies. Such a disconnect underscores the need to sensitise health care providers about the special needs and vulnerability of married young people, including young newly-weds, and to orient them to the need for developing appropriate strategies to reach them.

In conclusion, findings of this study have highlighted the multiple risks faced by married young women and men in settings characterised by early marriage. These risks persist irrespective of whether it is a high or low HIV prevalence setting. Findings stress that married youth are a particularly vulnerable group in need of multi-pronged programmatic attention that will address not only their own risk behaviours but also the likely factors contributing to these risks. These programmatic efforts need to go beyond building in-depth awareness about sexual and reproductive health matters; efforts are needed to reposition the condom as an acceptable contraceptive

method for married young people and to support newly married young people to achieve their reproductive intentions, including delaying the first pregnancy and having a safe pregnancy and childbirth. Equally important are efforts to reverse traditional notions of masculinity and femininity that undermine young people's ability to achieve safe and wanted sexual and reproductive health outcomes. Programmes need to address not only married young people themselves but also their families, the community and health care providers who also play a significant role in enabling married youth to make informed, safe and wanted sexual and reproductive health choices.

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